

Malpractice, Mediation, and Moral Hazard: The Virtues of Dodging the Data Bank

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ABSTRACT

Health care has witnessed a rapid growth in the use of alternative dispute resolution. Nationwide, many hospitals are adopting early dispute resolution programs in which, when they err, they approach injured patients with disclosure, apology, and restitution. The results have generally been outstanding—better serving patients' and families' needs, and better for institutions as they save large sums on defense costs while improving safety and quality of care.

Unfortunately, physicians are largely left standing on the sidelines. Medical malpractice payments, no matter how small, and no matter why they were made, must generally be reported to the National Practitioner Data Bank, where they remain as a black mark for the rest of the physician's professional life. Weighing the high odds of winning if they defend in litigation, versus a guaranteed black mark if they settle early, physicians are not often interested in early mediation.

The literature is remarkably silent about this enormous disconnect. This article attempts to fill that void, exploring why physicians commonly abjure early mediation and recommending several specific, lawful ways for them to avoid the data bank and thereby embrace early dispute resolution. In the process, the article addresses the "moral hazard" issues attendant to dodging the data bank, so that ultimately physicians should be able to take a more active role in early mediation of medical malpractice disputes.

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OVERVIEW

There is little doubt that the current litigation system for addressing medical injuries is fraught with problems. Although its goals include justice and compensation for those wrongfully injured, and deterrence to prevent similar errors in the future, evidence suggests these goals are not well met. Although tort liability is sometimes the only way to achieve justice, compensation and quality improvement have proven to be far more elusive goals.

Compensation is poorly served because most negligently caused injuries never result in a claim, while a large proportion of filed claims are not connected with negligent injury, and the majority of damage awards overall goes to pay for attorney fees and expenses. Similarly, litigation's deterrence function poorly serves quality improvement. Most adverse events are the result, not so much of an individual provider's error, as of complex system flaws that can only be explored and rectified with information from everyone—physicians, nurses, administrators, patients, and families. Unfortunately, litigation tends to inhibit this much-needed communication.

In recent years, however, some hospitals have discovered the benefits of broad communication and early resolution. When these hospitals' internal investigations reveal they have erred, disclosure, apology, and mediation can compensate patients and families better, preserve important relationships, save the hospital substantial sums on defense costs, shorten times to resolution, reduce the number of outstanding lawsuits, and permit the detailed exploration that can improve quality on the systems-level. Part I of this article will discuss the history, advantages, and recent developments in early dispute resolution.

In theory, early dispute resolution should be equally attractive to physicians. As discussed in Part II, however, the National Practitioner Data Bank (NPDB) poses a major barrier. Created as part of the Health Care Quality Improvement Act of 1986 (HCQIA), the NPDB maintains a permanent record of adverse professional events for physicians, including payments made to resolve medical malpractice claims. These NPDB reports are permanent. Although the details are kept confidential from the public, hospitals must query the Data Bank when initially credentialing, and every two years thereafter, for each physician on their medical staff.

The NPDB thus forces an unhappy choice on physicians considering early resolution. If they fight the matter all the way through trial, physicians have very strong odds of winning. But if they settle early the consequence

may be a permanent “black mark” in the Data Bank, even if early settlement is otherwise better for everyone.

On closer inspection, however, perhaps the NPDB need not loom so large. Certain exceptions to the reporting requirement are already well known, and will be detailed in Part II. They include paying out of pocket, oral rather than written claims, “corporate shield,” and other approaches.

Part III discusses another potential exemption from NPDB reporting. In recent years, many states have enacted pre-suit notification statutes requiring that a prospective plaintiff notify potential defendants prior to filing a medical malpractice claim—typically 60 or 90 days in advance. Although some malpractice insurers believe that they must report any settlement payouts made during this pre-suit notification period, this article argues to the contrary. Applicable case law and plain language suggest that a potential claim is not yet an actual claim, and that a preview of a future claim is not, itself, a present claim. Insurers thus should not report settlement payouts made during this statutory window of opportunity for early resolution.

Finally, Part IV will address the “moral hazard” issues that arise if we endorse minimizing NPDB reports. If the purpose of NPDB reports is to warn hospitals and state medical boards that a particular physician may be incompetent or otherwise problematic, it might seem inappropriate to recommend avoiding NPDB malpractice payment reports at every lawful opportunity. However, as Part IV will show, the NPDB is hardly a faithful documentation of poor-quality medical practice. For one thing, there is wide variation in the character of the events being reported. Many malpractice settlements are the product of a simple business decision that it is cheaper to settle than fight, while in other cases, physicians such as military doctors are only reported if extensive review reveals genuine malpractice. Additionally, the Department of Health and Human Services (DHHS) acknowledges substantial underreporting, essentially conceding that the mandate to report is simply unenforceable. Ultimately, a significant portion of the data are of such mixed and dubious quality that, as the expression goes, “garbage in, garbage out.”

Part IV also argues that the HCQIA’s focus on hospitals’ peer review committees as the major locus for monitoring physician performance has become archaic. Fewer and fewer physicians actually practice in hospitals, hence if the NPDB’s goal is to prevent incompetent physicians from moving state-to-state, hospital surveillance is no longer a reliable mechanism. Additionally, although hospital peer review remains an important function for other reasons, it should focus on physicians’ actual medical practices, not on an odd collection of largely uninterpretable data.

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Fortunately, newer forms of continuing quality review are arising from emerging payment systems such as “value-based purchasing” and from new forms of health care delivery such as Accountable Care Organizations. As payers look more for quality of outcomes than quantity of inputs, the new provider organizations are creating solid financial incentives to provide comprehensive, high-quality care. This will require far more careful monitoring of physicians’ performance than a biennial inspection of dubious entries in a Data Bank.

Finally, and perhaps most importantly, to the extent that the NPDB deters physicians from entering into early dispute resolution, the result can be far more harmful to quality improvement—the central focus of the Health Care Quality Improvement Act—than any putative benefits from mandating malpractice payment reports. In the end, dodging the Data Bank is not merely permissible, it is, on the whole, desirable.

I. EARLY DISPUTE RESOLUTION: EVOLUTION AND ADVANTAGES

For a patient suffering an adverse event from medical care, the legal system’s standard remedy is tort litigation, whose goals are justice, compensation for those injured by others’ negligence, quality improvement via deterrence, and sometimes punishment.¹

A. Litigation’s Failures to Meet its Goals

Unfortunately, litigation often fails to satisfy these goals in medical malpractice cases. Although sometimes a lawsuit is the only way to achieve justice, litigation generally does poorly in compensating losses or improving quality of care. Compensation is poorly served partly because the substantial majority of negligent iatrogenic² injuries do not lead to a filed claim (especially injuries that are financially too small to warrant attorneys’ interest), and reciprocally the majority of filed claims are not associated with

¹ Edward A. Dauer & Leonard J. Marcus, *Adapting Mediation to Link Resolution of Medical Malpractice Disputes with Health Care Quality Improvement*, 60 LAW & CONTEMP. PROBS. 185, 185 (1997).

² “Iatrogenesis” and “iatrogenic injury” refer to adverse outcomes caused by physicians or surgeons, or by the health care process. DORLAND’S ILLUSTRATED MEDICAL DICTIONARY, 646–47 (26th ed., 1981). The term should not be confused with negligence. An infection, for instance, may be an iatrogenic injury caused by chemotherapy for cancer. It is usually, however, a known and accepted result of the immunologic effects of the chemotherapy—not negligent, but physician-caused nonetheless.

negligent iatrogenesis.³ Even among filed cases, the odds quite strongly favor defendants. The majority of filed cases are dropped, and, of those that actually make it to trial, defendants prevail the great majority of the time.⁴ Even where the plaintiff prevails, the majority of the award on average goes to cover attorneys' fees and expenses.⁵

In like manner, litigation does poorly as a vehicle for improving quality—which purportedly is to occur via deterring similar negligent

³ Dauer & Marcus, *supra* note 1, at 190 n.4 (“Andrews et al. reported serious injuries at a rate of 17.7%, with claims for compensation at only 1.2%. See Lori B. Andrews et al., *An Alternative Strategy for Studying Adverse Events in Medical Care*, 349 LANCET 309, 312 (1997). The Harvard study found that one out of seven patients injured through actionable negligence made claims (assuming that all claims made came from the pool of negligent events), and that one out of five cases where negligence caused death or at least six months of disability resulted in a paid claim.” Dauer & Marcus, *supra* note 1, at 185, 190; Troyen A. Brennan et al., *Relation Between Negligent Adverse Events and the Outcomes of Medical-Malpractice Litigation*, 335 NEW ENGL. J. MED. 1963, 1963–67 (1996). See also William M. Sage et al., *Bridging the Relational-Regulatory Gap: A Pragmatic Information Policy for Patient Safety and Medical Malpractice*, 59 VAND. L. REV. 1263, 1271 (2006); Florence Yee, *Mandatory Mediation: The Extra Dose Needed to Cure the Medical Malpractice Crisis*, 7 CARDOZO J. CONFLICT RESOL. 393, 425 (2006).

⁴ David M. Studdert et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 NEW ENGL. J. MED. 2024, 2026 (2006) (finding that, of the 15% of claims that were decided by trial verdict, plaintiffs prevailed only 21% of the time).

More recently, a study by the American Medical Association found, on the basis of data from the Physician Insurers Association of America, that in 2008, 65% of claims were dropped, dismissed, or withdrawn; 25.7% were settled, and only 5% were resolved by trial. Of those that went to trial, physician defendants prevailed 90% of the time. Carol K. Kane, MEDICAL LIABILITY CLAIM FREQUENCY: A 2007–2008 SNAPSHOT OF PHYSICIANS, available at <http://www.ama-assn.org/ama1/pub/upload/mm/363/prp-201001-claim-freq.pdf>.

In Tennessee in 2008 the figures were even more dramatic. Of 3,154 claims closed in the state in 2008, only 425 were resolved through judgment at trial. Of those, the defendant prevailed in 420, with plaintiff taking nothing. TENN. DEP'T OF COM. & INS., 2009 MEDICAL MALPRACTICE CLAIMS REPORT 4, 6 (Nov. 1, 2009), <http://www.tn.gov/commerce/insurance/documents/2009MedicalMalpracticeClaimsReport.pdf>.

⁵ See, e.g., Studdert et al., *supra* note 4, at 2028–29. One recent study found that “for every dollar spent on compensation, 54 cents went to administrative expenses (including those involving lawyers, experts, and courts).” The study also found that 37% of the claims examined did not involve errors; claims not involving errors accounted for between 13% and 16% of the system's total monetary costs. *Id.*

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performance in the future by this and other providers. Deterrence as quality improvement, however, is problematic in several ways.

First, litigation tends to inspire costly and sometimes harmful defensive medicine, loosely defined as “tests and procedures ordered by physicians principally to reduce perceived threats of medical malpractice liability.”⁶ Studies have shown that the extra tests and treatments physicians order in the effort to ward off perceived risks of litigation can increase healthcare costs by billions annually and can, themselves, cause a cascade of further testing and iatrogenic injury.⁷

Second, litigation can impair providers’ quality of performance. Evidence suggests that physicians named in a lawsuit tend to suffer a marked increase in symptoms of depression, including fatigue, insomnia, difficulty in concentrating, decreased self-confidence, or a loss of nerve in clinical activities.⁸ Physicians named in a suit also have an increased chance of being named in another suit within the first two years.⁹ More recent data show that surgeons who had committed a major error experienced a three-fold increase

⁶ J. William Thomas et al., *Low Costs Of Defensive Medicine, Small Savings From Tort Reform*, 29 HEALTH AFF. 1578, 1578 (2010).

⁷ See Richard E. Anderson, *Billions for Defense: The Pervasive Nature of Defensive Medicine*, 159 ARCHIVES OF INTERNAL MED., 2399, 2399; Randall R. Bovbjerg et al., *Defensive Medicine and Tort Reform: New Evidence in an Old Bottle*, 21 J. HEALTH POL. POL’Y & L., 267–88 (1996); Emily R. Carrier et al., *Physicians’ Fears of Malpractice Lawsuits Are Not Assuaged by Tort Reforms*, 29 HEALTH AFF., 1585, (2010); Dauer & Marcus, *supra* note 1, at 191–92; Michelle M. Mello et al., *National Costs of the Medical Liability System*, 29 HEALTH AFF. 1569, 1572–74 (2010); David M. Studdert et al., *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment*, 293 JAMA 2609, 2609–17 (2005).

⁸ Edward A. Dauer, *A Therapeutic Jurisprudence Perspective on Legal Responses to Medical Error*, 24 J. LEGAL MED. 37, 43 (2003). “Sara Charles, a psychiatrist at the University of Illinois, ‘found distinct elevations in what she termed “depressive symptom clusters”—increased incidences of, for example, fatigue, insomnia, difficulty in concentrating, headache and other physical illnesses, suicidal ideation, and a sharp (nearly tripled) increase in excessive alcohol use. Other subjective reports showed lower self-esteem, decreased self-confidence, “loss of nerve” in clinical situations, increased sense of being misunderstood and of being defeated; and marked increases in reports of anger, inner tension, depressed mood, frustration, and irritability.’” *Id.*

⁹ See *id.* at 45. Theodore Passineau, Manager of Physician Risk Management at the Farmer’s Insurance Group observed that “[p]hysicians against whom claims had been made had, in the first quarter following that first claim, a nearly 15% risk of experiencing a loss; an odds ratio (OR) of nearly 3:1 over the average for all practitioners in the group. The elevated risk extinguished over time, the OR slowly declining to about 1:1 after two years.” *Id.* See also Yee, *supra* note 3, at 423–24.

in suicidal ideation during the three months following the error, “with 16.2% of surgeons who reported a recent major error experiencing [suicidal ideation] compared with 5.4% of surgeons not reporting an error.”¹⁰

Third, and most important for present purposes, litigation’s deterrence approach to quality improvement tends to inhibit communication at a time when robust communication is most urgently needed.¹¹ By the early 1990s, health policy scholars had solidly established that errors in health care were most often due, not to the single actions of an errant individual, but to complex concatenations of system-level factors. As Lucian Leape pointed out in 1994, health system errors caused some 180,000 deaths per year, or “the equivalent of three jumbo-jet crashes every [two] days.”¹² He and others imported concepts of “Total Quality Management” and “Continuous Quality Improvement”¹³ into health care, emphasizing that systems-level improvement requires “(1) a culture in which errors and deviations are regarded not as individuals’ failures but as opportunities to improve the system, (2) a ‘grassroots’ participation in identifying errors and their sources, and the ways to system modification, and (3) a commitment to TQM from organizational leadership.”¹⁴ Numerous scholars have explored the complex

¹⁰ Taid D. Shanafelt et al., *Suicidal Ideation Among American Surgeons*, 146 ARCHIVES OF SURGERY 54, 57 (2011).

¹¹ Carol B. Liebman & Chris Stern Hyman, MEDICAL ERROR DISCLOSURE, MEDIATION SKILLS, AND MALPRACTICE LITIGATION: A DEMONSTRATION PROJECT IN PENNSYLVANIA, 2–3 (2005), available at http://www.pewtrusts.org/uploadedFiles/wwwpewtrustsorg/Reports/Medical_liability/LiebmanReport.pdf. See also *id.* at 10 (“[c]onfrontational litigation is antithetical to meaningful communication after an error or adverse event. Instead of mistrust and anger, patients and survivors need to feel understood and respected. . . . Timely communication helps physicians and hospitals receive valuable information relevant to patient safety.”).

¹² Lucian L. Leape, *Error in Medicine*, 272 JAMA 1851, 1851 (1994).

¹³ “Continuous Quality Improvement” is a term initially introduced to describe quality improvement in industry, by writers such as W. Edwards Deming, *OUT OF THE CRISIS* (1986), Joseph Juran, *QUALITY CONTROL HANDBOOK* (1951), and Philip Crosby, *QUALITY IS FREE* (1979). It was subsequently expanded to health care. See, e.g., Curtis P. McLaughlin & Arnold D. Kaluzny, *CONTINUOUS QUALITY IMPROVEMENT IN HEALTH CARE: THEORY, IMPLEMENTATIONS, AND APPLICATIONS* (3d ed. 2006) (discussing both Total Quality Management/TQM and Continuous Quality Improvement/CQI in health care).

¹⁴ Dauer & Marcus, *supra* note 1, at 198 (citing Laura Morlock & Faye Malitz, *Do Hospital Risk Management Programs Make a Difference? Relationships Between Risk Management Program Activities and Hospital Malpractice Claims Experience*, 54 LAW & COMTEMP. PROBS. 1, 21 (1991)).

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roles that systems play in creating latent failures and other factors that, in turn, conduce to adverse events.¹⁵

Thus, if we wish to improve health care following an adverse event, we must first understand what the problem was. To understand what the problem was we must understand, in detail, what actually happened. And to understand what actually happened, we must retreat from the historically common “name, blame, and shame” response to a more productive approach that favors thorough, ongoing communication and problem-solving.¹⁶ The adversarial tort system, focused as it is on pinpointing blame, systematically inhibits essential communication and thereby impairs system-level quality improvement.¹⁷ As observed by Dauer and Marcus:

Individuals do make errors and should be responsible for the quality of their work. Nevertheless, the “bad apple” approach of the tort system focuses on outliers rather than on more pervasive influences. It looks at outliers as if they were significant when in fact they are most often highly unusual and sometimes random events. The strategy of quality improvement system design, by contrast, is to recognize that errors occur, to recognize that people work within systems, and to design the systems to do two things: (1)

¹⁵ See COMMITTEE ON QUALITY OF HEALTHCARE IN AMERICA, INSTITUTE OF MEDICINE, *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM* 29–32, 58–66 (Linda T. Kohn et al., eds., 2000); see also David Blumenthal, *Total Quality Management and Physicians’ Clinical Decisions*, 269 JAMA 2775, 2775–78; David Blumenthal & Charles M. Kilo, *A Report Card on Continuous Quality Improvement*, 76 THE MILBANK QUARTERLY 625, 625–48 (1998); Thomas Bodenheimer, *The American Health Care System: The Movement for Improved Quality in Health Care*, 340 NEW ENGL. J. MED. 488, 488–90 (1999); Mark R. Chassin, *Is Health Care Ready for Six Sigma Quality?*, 76 THE MILBANK QUARTERLY, 565, 565–78 (1998); Avedis Donabedian, *The Quality of Care: How Can it Be Assessed?*, 260 JAMA 1743, 1743–48 (1988); David M. Eddy, *Clinical Policies and the Quality of Clinical Practice*, 307 NEW ENGL. J. MED. 343, 343–47 (1982); Stephen F. Jencks & Gail R. Wilensky, *The Health Care Quality Improvement Initiative*, 268 JAMA 900, 900–03 (1992); Glenn Laffel & Donald Berwick, *Quality in Health Care*, 268 JAMA 407, 407–08 (1992); Glenn Laffel & David Blumenthal, *The Case for Using Industrial Quality Management Science in Health Care Organizations*, 262 JAMA 2869, 2869–70 (1989).

¹⁶ REPORT OF THE QUALITY INTERAGENCY COORDINATION TASK FORCE (QUIC) TO THE PRESIDENT, February 2000, *DOING WHAT COUNTS FOR PATIENT SAFETY: FEDERAL ACTIONS TO REDUCE MEDICAL ERRORS AND THEIR IMPACT* (2000), available at <http://www.quic.gov/report/toc.htm>. See also Timothy McDonald et al., *Responding to Patient Safety Incidents: the “Seven Pillars,”* 19 QUALITY & SAFETY IN HEALTH CARE e11, e11 (2010) 19th ed., available at <http://qualitysafety.bmj.com/content/19/6/1.31.full.pdf>.

¹⁷ Dauer & Marcus, *supra* note 1, at 198–99, 204.

to make it difficult for individuals to make errors and (2) to make the whole system capable of “absorbing” individuals’ errors when they occur by identifying and correcting errors before they can be harmful. Even when a doctor has committed an error of judgment or skill, a systems approach demands to know how and why that infraction came about.¹⁸

The point is illustrated well by the Root Cause Analysis (RCA) of a serious medication error in which a nurse caring for a sixteen-year-old obstetric patient mistakenly infused epidural anesthesia medications into the intravenous port intended for antibiotics.¹⁹ The patient suffered virtually immediate cardiovascular collapse and died.²⁰ A litigation-based approach to quality improvement following such an event would emphasize deterrence: Blame and shame the nurse for such obvious carelessness and thereby deter her and onlookers from future such negligence.

As a careful RCA of the events revealed, however, the realities were far more complex.²¹ Among other factors, the infusion bags for the two kinds of medication were nearly identical, and the ports were fully interconnectable—even though epidural medications should only be administered intrathecally (into the spinal canal), never intravenously, and the antibiotics should be administered intravenously.²² Moreover, the nurse had worked two straight shifts the day before, with barely eight hours off in between those two and the present shift because she had agreed to cover for a colleague.²³ This nursing unit had a policy of using only its own nurses rather than drawing nursing help from elsewhere in the hospital, hence any shortage of manpower could only be addressed by another nurse within the unit.²⁴ Numerous other system-level problems also were identified, such as the glitches in bringing

¹⁸ *Id.* at 195. For a detailed discussion of the differences between tort versus systems-improvement approaches to medical error, *see id.* at 196–98.

¹⁹ Judy Smetzer et al., *Shaping Systems for Better Behavioral Choices: Lessons Learned from a Fatal Medication Error*, 36 J. COMM’N J. ON QUALITY & PATIENT SAFETY 152, 152–63 (2010).

²⁰ *Id.*

²¹ *Id.* *See also* Sidney W.A. Dekker, *We have Newton on a Retainer: Reductionism When We Need Systems Thinking*, 36 J. COMM’N J. ON QUALITY & PATIENT SAFETY 147, 147–49 (2010); Charles R. Denham, *The Missing Safe Practice*, 36 J. COMM’N J. ON QUALITY & PATIENT SAFETY 149, 149–50 (2010); Lucian L. Leape, *Who’s to Blame?*, 36 J. COMM’N J. ON QUALITY & PATIENT SAFETY 150, 150–51 (2010).

²² Smetzer, et al. *supra* note 19, at 156–57.

²³ *Id.*

²⁴ Denham, *supra* note 21, at 149.

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the hospital's new bar code ID and medication-reader system online.²⁵ In the end, a highly skilled nurse with thirteen years' exemplary performance was criminally indicted and her license was suspended for nine months.²⁶

If there is a lesson here, it is that quality is not optimally improved by simply demanding that inherently fallible human beings be ever more obsessively attentive.²⁷ People become fatigued, distracted, or inattentive, and safety systems must plan for this. Here, an exhausted nurse was caring for a terrified sixteen-year-old, and also for a young woman who knew that her labor would produce only a stillborn infant.²⁸ Rather than satisfying ourselves with indictments and license revocation, we need to recognize that quality improvement is often better served, not by punitive responses, but by constructing system-level safeguards to reduce the chances of error.²⁹

To the extent that tort litigation's approach to quality improvement emphasizes individual culprits, presumes that errors are mainly the product of individual persons' failings, and recommends making those individuals pay a personal price so that they will be more attentive next time, it is out of touch with contemporary realities of quality and safety improvement in complex systems such as health care. Rather, free-flowing communication and problem-solving are required.³⁰

Unfortunately, litigation tends severely to inhibit such communication. Insurers have historically urged physicians not to discuss the case with the patient/family once an adverse event has occurred, lest they say something that could, as an admission by a party opponent,³¹ work against them later.³²

²⁵ Dekker, *supra* note 21, at 147–148; Smetzer et al., *supra* note 19, at 153–59.

²⁶ The nurse's license was suspended for nine months per a consent agreement. *See* In the Matter Of Disciplinary Proceedings against Julie Thao, R.N., Dec. 14, 2006, Wisconsin Department of Regulation & Licensing, No. LS0612145NUR, <https://online.drl.wi.gov/decisions/2006/ls0612145nur-00075545.pdf>.

²⁷ Recent evidence from the nursing home industry confirms the same finding for long-term care. *See* David M. Studdert et al., *Relationship Between Quality of Care and Negligence Litigation in Nursing Homes*, 364 NEW ENGL. J. MED. 1243, 1243–50 (2011) (finding there is very little difference in the rate of negligence litigation between institutions exhibiting high quality of care and those exhibiting considerably lower quality of care).

²⁸ Smetzer et al., *supra* note 19, at 157.

²⁹ This is not to say, of course, that punitive responses to error are never appropriate. Particularly where an error is the product of an individual's conscious indifference to safety and quality concerns, punitive approaches can be the best option.

³⁰ Liebman, *supra* note 11, at 39–40.

³¹ *See* FED. R. EVID. 801(2)(c).

Co-defendants who initially collaborate may quickly fall into mutual finger-pointing, further shutting down communication. Physicians may also be counseled against speaking with uninvolved physicians—at a time when they may most need to reflect with colleagues about what happened—lest those colleagues be subpoenaed to testify.³³ Attorneys in discovery commonly play a drawn-out game of “hide the ball,” revealing as little as possible as slowly as possible, perhaps to make the case as difficult and expensive as possible for the opposing party.³⁴ Thus, “formal discovery is a cumbersome and disjointed process involving sporadic provision of information, which plaintiffs must then piece together to construct the overall timeline and flow of factual information.”³⁵ And in the end, patients or families whose main reason for filing suit may have been because no one would tell them what happened³⁶ may never receive answers to those questions.³⁷

³² See John D. Banja, *Does Medical Error Disclosure Violate the Medical Malpractice Insurance Cooperation Clause?*, 3 ADVANCES IN PATIENT SAFETY: FROM RESEARCH TO IMPLEMENTATION 371 (Kerm Henriksen et al., eds., 2005) (arguing that, despite a contractual clause requiring physicians to cooperate with their insurers in the event of potential litigation, medical malpractice insurers have never successfully penalized a physician for honest communication with injured patients; noting also that failure to communicate honestly may raise, rather than reduce, the likelihood of litigation).

³³ Andrew Feld & Richard Moses, *Most Doctors Win: What to Do if Sued for Medical Malpractice*, 104 AM. J. GASTROENTEROLOGY 1346, 1348 (2009). See also Liebman, *supra* note 11, at 41–42.

³⁴ William M. Sage, *The Forgotten Third: Liability Insurance and the Medical Malpractice Crisis*, HEALTH AFF. 10, 10–11 (2004) (“Information about the cause of injuries is denied patients and families for prolonged periods, compensation is unavailable when it is most needed, and quality feedback to providers is attenuated to the point of uselessness.”).

³⁵ Dale C. Hetzler, *Superordinate Claims Management: Resolution Focus from Day One*, 21 GA. ST. U. L. REV. 891, 892 (2005).

³⁶ See, e.g., Howard B. Beckman et al., *The Doctor-Patient Relationship and Malpractice: Lessons from Plaintiff Disposition*, 154 ARCHIVES OF INTERNAL MED. 1365, 1368 (1994) (finding doctor-patient relationship issues as key factors behind patient complaints). See also Gerald B. Hickson et al., *Factors That Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries*, 267 JAMA 1359, 1361 (1992); Wendy Levinson, *Physician-Patient Communication: A Key to Malpractice Prevention*, 272 JAMA 1619, 1619 (1994) (“Malpractice attorneys asked to cite the primary reason the patient pursued a malpractice suit report that more than 80% are due to communication issues. . . . 35% were due to physician attitudes (in a hurry, air of superiority. . . . 7% were due to physician disparagement of previous care, and 5% were due to unrealistic patient expectation.”); Charles Vincent et al., *Why Do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action*, 343 LANCET 1609, 1611

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B. *Advantages and Successes in Early Dispute Resolution*

Early dispute resolution, including interest-based mediation, stands in sharp contrast to litigation as a means of addressing adverse outcomes. It begins with the recognition that financial compensation is not the only important goal. Injured patients and families commonly have many other objectives.³⁸

Simply finding out what happened is often a preeminent goal, particularly where providers appear to have “circled the wagons,” offering only silence or evasiveness.³⁹ Patients and families also often insist that “this must not happen to anyone else,” expressing a strong interest in improving quality and safety.⁴⁰ Despite the adverse outcome, they may also want to preserve a provider-patient relationship on which they may have relied for many years.⁴¹ These and other goals are not well served by a litigation in which each party retreats to a fortified bunker, communicating with the other only via highly-paid messengers.

The stark contrast between the limited goals served by litigation, and the broader goals parties actually seek, has recently become a key focus for a growing number of hospitals. As early as the 1980s, a Veterans Administration hospital in Lexington, Kentucky announced its success with a program dubbed “extreme honesty.”⁴² Instead of the customary approach in which a hospital, even when aware it had erred, would remain silent and hope the patient never found out, this hospital opted instead to embrace

(1994).

³⁷ Litigation typically requires around five years to resolve. Sage, *supra* note 34, at 11; see also Yee, *supra* note 3, at 407.

³⁸ Carol Liebman & Chris Hyman, *A Mediation Skills Model to Manage Disclosure of Errors and Adverse Events to Patients*, 23 HEALTH AFF. 22, 24 (2004).

³⁹ See generally SANDRA M. GILBERT, *WRONGFUL DEATH: A MEMOIR* (1995); Tom Delbanco & Sigall K. Bell, *Guilty, Afraid, and Alone—Struggling with Medical Error*, 357 NEW ENGL. J. MED. 1682, 1682–83 (2007); Anna C. Mastroianni, Michelle M. Mello, Shannon Sommer, Mary Hardy & Thomas H. Gallagher, *The Flaws in State ‘Apology’ and ‘Disclosure’ Laws Dilute Their Intended Impact on Malpractice Suits*, 29 HEALTH AFF. 1611, 1612 (2010).

⁴⁰ See Dale C. Hetzler, *Superordinate Claims Management: Resolution Focus from Day One*, 21 GA. ST. U. L. REV. 891, 894 (2005).

⁴¹ *Id.* (“In addition, many potential plaintiffs are still patients or wish to remain patients, so they want to maintain that relationship.”).

⁴² Steve S. Kraman & Ginny Hamm, *Risk Management: Extreme Honesty May be the Best Policy*, 131 ANNALS OF INTERNAL MED. 963, 966–67 (1999).

affirmative disclosure.⁴³ The hospital's protocol called for informing the patient/family that it had made an error, convening meetings with the patient/family (encouraging them to be represented by counsel), explaining what happened and what further investigations and safety improvements were underway as a result of the event, and offering compensation.⁴⁴ Nearly a decade after the project began, total malpractice payments placed the hospital in the bottom quartile of its peer group.⁴⁵

Other hospitals have advanced the concept. Beginning in the late 1990s the University of Michigan Health System (UMHS) began an active disclosure-with-offer program. By 2001, UMHS "began responding to all open and new malpractice claims by admitting fault and offering compensation when an internal investigation reveals medical error. If an investigation reveals no error, UMHS provides the reasons for its conclusion and vigorously defends a claim, if necessary. In April 2002, UMHS began linking the investigation process with peer review and quality improvement efforts."⁴⁶

By February 2003, the disclosure program was fully integrated with patient safety efforts. The program now identifies patient injuries through various means, including reporting by employees, patients or family members, or patients' attorneys. It uses experienced risk managers with clinical backgrounds to lead investigations and mediate patient concerns as facts are collected, care quality is evaluated, and conclusions are disclosed. The UMHS emphasizes honesty and transparency with patients and staff, regardless of whether events resulted from error, and encourages staff to enlist risk management in the disclosure process.⁴⁷

Every patient and his lawyer is invited to confer about the problems that arose during the patient's care, where "[o]pen, honest, and robust discussions occur Expert opinions are exchanged and agreements are reached—agreements to drop the claim, agreements to settle (sometimes with an

⁴³ *Id.* at 963.

⁴⁴ *Id.* at 966–67 (1999); see also Albert W. Wu, *Handling Hospital Errors: Is Disclosure the Best Defense?*, 131 ANNALS OF INTERNAL MED. 972, 972–73 (1999).

⁴⁵ Kraman, *supra* note 42. See also Allen Kachalia et al., *Liability Claims and Costs Before and After Implementation of a Medical Error Disclosure Program*, 153 ANNALS OF INTERNAL MED. 213, 219 (2010).

⁴⁶ Kachalia, *supra* note 45, at 213–14. See also Richard C. Boothman et al., *A Better Approach to Medical Malpractice Claims? The University of Michigan Experience*, 2 J. HEALTH & LIFE SCI. L. 125, 137–46 (2009).

⁴⁷ Kachalia, *supra* note 45, at 213–14.

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apology), and occasionally, agreements to disagree. Patients develop a thorough understanding of what happened before misconceptions and bogus information drive them to the courthouse.”⁴⁸

Once the program had been fully operational for several years, the results were striking:

[The] average monthly rate of new claims decreased from 7.03 to 4.52 per 100,000 patient encounters ... The average monthly rate of lawsuits decreased from 2.13 to 0.75 per 100,000 patient encounters ... Median time from claim reporting to resolution decreased from 1.36 to 0.95 years. Average monthly cost rates decreased for total liability . . . patient compensation ... and non-compensation-related legal costs....⁴⁹

The cost per lawsuit decreased from \$405,921 to \$228,308.⁵⁰ Equally important, these savings have been redirected into quality improvement projects.⁵¹

Other medical centers have reported similar experiences. In the late 1990s, Children’s Healthcare of Atlanta (Children’s) began applying an interest-based approach to claims resolution, in the recognition that “[p]laintiffs with health care disputes generally want three things: (1) to know why or how the incident happened, (2) to learn what the provider has done to prevent a recurrence, and (3) to receive sincere apology.”⁵² Injured patients and families were encouraged to retain legal representation. Rather than the evasive communication familiar in litigation, the role of the litigation manager was to provide and explain non-privileged information as fully and quickly as possible, to answer questions and explore patients’ and families’ concerns, and to try to use the lessons learned to improve the institution’s quality of care.⁵³

The savings that accrued for Children’s were significant, even as the process lent far greater respect to patients’ and families’ goals. Total time to resolution went from 36 down to 18 months, while defense costs were reduced about \$52,000 per case.⁵⁴ These tended to mirror the 50-80% savings realized by non-healthcare organizations that likewise shifted from

⁴⁸ Boothman, *supra* note 46, at 142.

⁴⁹ Kachalia, *supra* note 45, at 213.

⁵⁰ *Id.* at 217.

⁵¹ Boothman, *supra* note 46, at 145.

⁵² Hetzler, *supra* note 40, at 894 (citing Liebman, *supra* note 38, at 22).

⁵³ *Id.* at 894–95.

⁵⁴ *Id.* at 896.

traditional litigation-based conflict management to an early resolution approach.⁵⁵

A number of other health care institutions have likewise moved away from litigation and toward early resolution, with a focus on enhancing information exchange and addressing the concerns that are most important to each party in the process.⁵⁶ Overall quality improvement is deemed an important result for providers and patients alike.⁵⁷ Not all institutions are fully aware yet of the potential for safety improvements alongside financial savings, but the spectrum of benefits is becoming increasingly evident.⁵⁸

⁵⁵ Karl A. Slaikeu & Diane W. Slaikeu, *Confidential from General Counsel to CEO: "I'm Fed Up, and We're Not Going to Take This Anymore!"*, 5 J. HEALTH CARE L. & POL'Y 335, 342 (2002) (describing early dispute resolution in a variety of industries).

⁵⁶ These institutions are said to include Kaiser Permanente, Children's Hospital and Clinics of MN, Johns Hopkins, Catholic Healthcare West, Chicago Rush-Presbyterian-St. Luke's Medical Center, Drexel University College of Medicine, Minnesota Fairview Hospitals, University of Pittsburgh Medical Center, University of Illinois at Chicago. See Boothman, *supra* note 46, at 146–47; Chris S. Hyman et al., *Interest-Based Mediation of Medical Malpractice Lawsuits: A Route to Improved Patient Safety?*, 35 J. HEALTH POL. POL'Y & L. 797 (2010); Stephen Langel, *Averting Medical Malpractice Lawsuits: Effective Medicine—or Inadequate Cure?*, 29 HEALTH AFF. 1565 (2010); Yee, *supra* note 3, at 438–42; Max D. Brown, *Rush Hospital's Medical Malpractice Mediation Program: An ADR Success Story*, 86 ILL. B.J. 432, 432 (1998); Jonathan R. Cohen, *Apology and Organizations: Exploring an Example from Medical Practice*, 27 FORDHAM URB. L.J. 1447 (2000). See also Richard Blatt, Max Brown, & Jerome Lerner, *Co-Mediation: A Success Story at Chicago's Rush Medical Center*, available at <http://www.adrsystems.com/news/Co-Mediation.pdf>; Liebman, *supra* note 11, at 53–56; Christopher Guadagnino, *Malpractice Mediation Poised to Expand*, PHYSICIAN'S NEWS DIGEST (April 2004), <http://www.physiciansnews.com/cover/404.html>; Robert A. Creo, Jacqueline O. Shogan, & Chatón T. Turner, *Malpractice Case Alternative Dispute Resolution*, PHYSICIAN'S NEWS DIGEST, available at <http://www.physiciansnews.com/2005/11/13/malpractice-case-alternative-dispute-resolution>.

⁵⁷ McDonald et al., *supra* note 16, at 3 (describing University of Illinois Medical Center at Chicago program in which an amplified safety reporting system resulted in more than 2000 annual incident reports, more than 100 disclosure conversations and twenty “full disclosures” of inappropriate or unreasonable care, which in turn translated into approximately 200 system improvements).

⁵⁸ Hyman, *supra* note 56, at 798, 813–815 (observing that defense attorneys sometimes are reluctant to mediate):

Although defense lawyers' reluctance to mediate may have resulted from misaligned interests of defendants and their lawyers (Wissler 2004), it seems likely that hospital and insurer clients failed to give their outside counsel instructions that would have led them to make better use of the mediation

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The advantages of this approach are not just financial. Early mediation is considerably more flexible than litigation, permitting parties to structure whatever outcome makes best for all under the circumstances.⁵⁹ Appropriate experts can be brought in to ensure that compensation accounts for future contingencies as well as known realities.⁶⁰ As noted by Boothman et al.:

By interrupting the march to the courthouse, the animosity intrinsic to suing someone is lessened and often avoided, which allows for discussions not impassioned by name-calling, threats of professional ruin, reinforced victimhood, exaggerated claims, and dismissive defenses. If it appears that compensation is owed, the discussion shifts from the typical approach, in which both sides take equally unreasonable financial positions and work towards a middle ground, evidence-based discussions about what is truly owed because of the medical error. With this approach, it is not uncommon for a settlement amount to be very close to the original offer and for both sides to agree on the substantive basis for the settlement.⁶¹

In theory, this sort of early dispute resolution should be at least as attractive to physicians as to hospitals.⁶² Hospitals also have a keen interest in improving quality to reduce future errors. And they, like many patients, may want to repair the relationship damage that an adverse outcome can cause, and to reach some sense of fairness and equilibrium for all in the process. Unfortunately, a significant roadblock stands in the way.

process (Shapiro 2008: 4). Medical malpractice defendants, who focus primarily on how to put off and ultimately limit payment to plaintiffs, tend to ignore the opportunity to learn from errors and repair damaged relationships and reputations, and therefore bear responsibility for the nonconciliatory attitudes shown by their lawyers.

Id. at 815 (citation omitted).

⁵⁹ Edward A. Dauer & Leonard J. Marcus, *Adapting Mediation to Link Resolution of Medical Malpractice Disputes with Health Care Quality Improvement*, 60 L. & CONTEMP. PROBS. 185, 199, 204 (1997); *See also* Yee, *supra* note 3, at 416–26.

⁶⁰ Boothman, *supra* note 47, at 156.

⁶¹ Boothman, *supra* note 47, at 142.

⁶² Some states actually require mediation soon after a suit is filed. *See, e.g.*, FLA. STAT. ANN. § 766.108 (WEST 2007) (“Mandatory mediation and mandatory settlement conference in medical negligence actions,” requiring mediation within 120 days after a suit is filed). *See also* W. VA. CODE § 55-7B-6(f), (g) (permitting defendant provider to require parties to mediate); S.C. CODE ANN. § 15-79-120 (mandating pre-suit mediation).

II. NATIONAL PRACTITIONER DATA BANK

For physicians, early mediation of the sort described above is relatively uncommon. For instance, of 3,154 medical malpractice claims closed in Tennessee in 2008, only 43, or 1.36%, were resolved through alternative dispute resolution, either mediation or arbitration.⁶³ One major reason is the fact that payments made to settle or pay a judgment for a medical malpractice claim will usually result in a permanent “black mark” in a record known as the National Practitioner Data Bank (NPDB).⁶⁴ Settling a malpractice claim thus carries a major disadvantage.

In contrast, physicians usually win if a case actually goes to trial.⁶⁵ That same year in Tennessee, only 425 of the 3,154 claims were resolved through judgment. Of those, the defendant prevailed in 420, with plaintiff taking nothing.⁶⁶ The math makes the decision appear obvious: Why settle early and incur a life-long black mark, when a physician can hold on for a highly likely victory later on.⁶⁷

⁶³ 2009 TENN. DEP’T OF COMMERCE & INS., MED. MALPRACTICE CLAIMS REP., *supra* note 4. In 2009 that figure rose to 9.87%, although it should be noted that this figure applies to other types of health care professionals in addition to physicians, such as dentists, podiatrists, chiropractors, and nurses. See 2010 TENN. DEP’T OF COMMERCE & INS., MED. MALPRACTICE CLAIMS REP., 4, 15, *available at* <http://www.state.tn.us/commerce/insurance/documents/2010MedicalMalpracticeClaimsReport.pdf>.

⁶⁴ John J. Fraser, Jr., & Committee on Medical Liability, *Technical Report: Alternative Dispute Resolution in Medical Malpractice*, 107 PEDIATRICS 602, 605 (2001); see also Teresa M. Waters et al., *Impact of the National Practitioner Data Bank on Resolution of Malpractice Claims*, 40 INQUIRY 283, 290 (2003); Lawrence E. Smarr, *A Comparative Assessment of the PIAA Data Sharing Project and the National Practitioner Data Bank: Policy, Purpose, and Application*, 60 L. & CONTEMP. PROBS., 59, 71 (1997); Michelle M. Mello & Thomas H. Gallagher, *Malpractice Reform—Opportunities for Leadership by Health Care Institutions and Liability Insurers*, 362 NEW ENGL. J. MED. 1353, 1355 (2010).

⁶⁵ See *supra* note 4 and accompanying text.

⁶⁶ 2009 TENN. DEP’T OF COM. & INS., MED. MALPRACTICE CLAIMS REP., *supra* note 4, at 6. The following year, of 177 claims resolved through judgment, defendants prevailed in 165 with no damages awarded to the plaintiff. 2010 TENN. DEP’T OF COM. & INS., MED. MALPRACTICE CLAIMS REP., *supra* note 63, at 7.

⁶⁷ Dwight Golann, *Dropped Medical Malpractice Claims: Their Surprising Frequency, Apparent Causes and Potential Remedies*, 30(7) HEALTH AFF. 1343, 1343, 1345 (2011); Anupam B. Jena et al., *Malpractice Risk According to Physician Specialty*, 365 NEW ENGL. J. MED. 629, 632–39 (2011).

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A. NPDB Origins and Physician Concerns

The NPDB was created as part of the Health Care Quality Improvement Act (HCQIA) of 1986.⁶⁸ The Act arose largely in response to a perceived need to reduce the incidence of malpractice,⁶⁹ and it sought to “restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician’s previous damaging or incompetent performance.”⁷⁰ Toward that end, the Act’s primary strategy was to ramp up hospital-based peer review, first by providing qualified immunity for those who participate in such review,⁷¹ second by providing broader information on which to base such review.⁷²

Qualified immunity was deemed necessary because many physicians feared serious antitrust litigation if their actions against a colleague were perceived more as anticompetitive than as quality improvement.⁷³ A broader information base was created by establishing the NPDB to serve as a repository for information about adverse licensure actions taken by state boards of medical examiners,⁷⁴ adverse professional review actions

⁶⁸ 42 U.S.C. § 11101 (2006).

⁶⁹ The Act was expressly not directed at the malpractice insurance crisis, but rather was directed at malpractice itself. See H.R. REP. NO. 99-903 (1986) *reprinted in* 1986 U.S.C.C.A.N. 6384.

⁷⁰ 42 U.S.C. § 11101(2) (2006).

⁷¹ Per 42 U.S.C. § 11112(a), the “professional review action must be taken—(1) in the reasonable belief that the action was in the furtherance of quality health care, (2) after a reasonable effort to obtain the facts of the matter, (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting” specified procedural requirements.

⁷² 42 U.S.C. §§ 11131-33 (2006)

⁷³ *Patrick v. Burget* was a case garnering particular attention at the time. Timothy Patrick, an Astoria, Oregon surgeon, developed difficult relationships with colleagues in the community, eventually leading to termination of Patrick’s hospital privileges. Although a jury found in favor of Dr. Patrick on his antitrust claim, the Ninth Circuit reversed, finding that the physician’s peer review activities fell within the state’s statute exempting peer review from antitrust scrutiny. The HCQIA was enacted that same year. Two years later the U.S. Supreme Court reversed the Ninth Circuit, holding that these particular peer review activities were not exempted from antitrust statutes. *Patrick v. Burget*, 800 F.2d 1498, 1509 (9th Cir. 1986), *rev’d* 486 U.S. 94, 105–06 (1988).

⁷⁴ See 42 U.S.C. § 11132 (2006).

undertaken by health care entities such as hospitals⁷⁵ and, of particular importance here, medical malpractice payments made on physicians' behalf.⁷⁶ The trigger for a medical malpractice report is found in § 11131(a), which provides:

Each entity (including an insurance company) which makes payment under a policy of insurance, self-insurance, or otherwise in settlement (or partial settlement) of, or in satisfaction of a judgment in, a medical malpractice action or claim shall report . . . information respecting the payment and circumstances thereof.

Section 11151(7) then defines a “medical malpractice action or claim” as “a written claim or demand for payment based on a health care provider’s furnishing (or failure to furnish) health care services, and includes the filing of a cause of action, based on the law of tort, brought in any court of any State or the United States seeking monetary damages.” A failure to report under this provision subjects the violator to a civil money penalty initially set at \$10,000, per § 11131(c).⁷⁷

The NPDB is not merely a dusty repository of facts. Section 11135(a)(1) requires hospitals to check the Data Bank regularly—initially, when a physician first applies to join its medical staff or to be granted privileges, and every two years thereafter. Other entities, such as managed care organizations, are permitted to access the information,⁷⁸ but hospitals are affirmatively required to make these regular checks. Likely this provision arose because, in the mid-1980s when HCQIA was enacted, most physicians

⁷⁵ 42 U.S.C. § 11133(a)(1) (2006).

⁷⁶ 42 U.S.C. § 11131 (2006). Of note, data collection extends to other practitioners besides physicians. *See* 42 U.S.C. § 11151(3) (2006) (“The term ‘physician’ means a doctor of medicine or osteopathy or a doctor of dental surgery or medical dentistry legally authorized to practice medicine and surgery or dentistry by a State (or any individual who, without authority holds himself or herself out to be so authorized).”). More recently, the Data Bank’s purview expanded to encompass essentially all health care practitioners and require that any negative finding, not just those related to competence or professionalism, be reported. *See National Practitioner Data Bank for Adverse Information on Physicians and Other Health Care Practitioners: Reporting on Adverse and Negative Actions*, 75 Fed. Reg. 4656 (Jan. 28, 2010).

⁷⁷ That figure is now \$11,000. U.S. DEP’T OF HEALTH & HUM. SERVICES, HEALTH RESOURCES AND SERVICES ADMINISTRATION, NATIONAL PRACTITIONER DATA BANK GUIDEBOOK, at A-4 (2001), available at <http://www.npdb-hipdb.hrsa.gov/resources/NPDBGuidebook.pdf> [hereinafter, NPDB GUIDEBOOK].

⁷⁸ 42 U.S.C. § 11137(a) (2006).

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maintained at least part of their practice in a hospital setting. Thus hospitals were fairly well-positioned to identify poorly performing practitioners and take appropriate action against their privileges. And if such a physician attempted to start anew in a different location, his or her next hospital would quickly find out about any prior adverse credentialing or licensure actions or medical malpractice payments, and either restrict that person's practice or refuse to provide credentials altogether.

This spectre of subsequent hospitals circumscribing a physician's medical practice, based on NPDB filings, has caused physicians considerable concern. There is no minimum dollar threshold for medical malpractice reports. Even a one-dollar payout must be reported. And that payment will never be erased from the Data Bank unless the Secretary of DHHS removes information that is inaccurate or is not reportable.⁷⁹ The report will follow the physician for the rest of his or her career.⁸⁰

Not surprisingly, a short time after the NPDB began collecting data in 1990, physicians became considerably less willing to settle cases, expressly

⁷⁹ NPDB GUIDEBOOK, *supra* note 77, at F-3 ("The Secretary [of DHHS] reviews disputed reports only for accuracy of factual information and to ensure that the information was required to be reported."). *See also* Straznicky v. Desert Springs Hosp., 642 F. Supp. 2d 1238, 1245 (D. Nev. 2009).

⁸⁰ Dauer & Marcus, *supra* note 59, at 191 n.30 ("The report is distributed every time the practitioner applies for new privileges at another facility, regardless of how often that occurs. There is no sunset for these reports. An NPDB record is forever. *See* Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11101–11152 (1994) (requiring the reporting of malpractice payments and maintenance of those records but not authorizing the deletion of records).") As noted by Metzloff et al. in their study of mediation in North Carolina:

Evidence from our study reveals that the Data Bank's reporting requirement is in fact a major issue in many malpractice cases. The Data Bank was a significant issue in twenty-five percent of the cases in which a defendant doctor subject to the reporting requirement was involved (eight of thirty-two cases). In fact, this percentage significantly understates the importance of the Data Bank issue. In several of the cases, liability was clear, and, predictably, the Data Bank was not a concern. In nearly fifty percent of the cases in which liability was an issue, the Data Bank was expressly referenced (eight of seventeen cases). In each of these cases, the affected doctor discussed the Data Bank as a major issue in the settlement of the case. Often, the doctor spoke personally to the mediator about the impact of the Data Bank.

Thomas B. Metzloff, Ralph A. Peebles & Catherine T. Harris, *Empirical Perspectives on Mediation and Malpractice*, 60 LAW & CONTEMP. PROBS. 107, 148 (1997) (citation omitted).

because of Data Bank concerns.⁸¹ To be sure, the Act emphasizes that a medical malpractice NPDB entry does not necessarily betoken actual malpractice.⁸² Nevertheless, the damage can be real.⁸³

In *Chudacoff v. Univ. Med. Ctr. of S. Nev.*, for instance, a university physician's privileges were suspended when he complained to his department chair about residents' inadequate skill levels and offered recommendations for improvements.⁸⁴ The Medical Executive Committee suspended his privileges and ordered him to undergo drug testing and various physical and mental examinations. The university president then terminated his employment because his privileges had been suspended, and the ensuing NPDB report cited various complaints against the physician.⁸⁵ Shortly thereafter, "other health care facilities notified Chudacoff that his privileges

⁸¹ See Waters et al., *supra* note 64, at 290; Smarr, *supra* note 64, at 71. See also Mello & Gallagher, *supra* note 64, at 1355.

⁸² 42 U.S.C. § 11137(d) (2006) ("In interpreting information reported under this subchapter, a payment in settlement of a medical malpractice action or claim shall not be construed as creating a presumption that medical malpractice has occurred."). See also 45 C.F.R. § 60.7(d) (2010).

⁸³ Hetzler, *supra* note 40, at 905. As noted by Dale Hetzler when describing his efforts to mediate comprehensive agreements at Children's Healthcare of Atlanta:

When a case involves physicians, great concern surrounds the advisability of settlement when liability is not clear. Unreconcilable expert opinions may make it unclear whether a jury would hold a physician responsible at trial. With their professional reputations at stake, physicians are appropriately cautious about using this approach. Until the government aligns the system of regulating the practice of medicine and reporting the resolutions of claims with the interest-based claims resolution process of disclosure and system improvement, comprehensive progress is not likely.

As likewise noted by Florence Yee:

Doctors fear reported settlement information can directly or indirectly negatively impact their ability to maintain good standing with their malpractice carriers, providers, peers, and patients, and may even jeopardize hospital staff privileges and medical board status. Therefore, physicians would rather bet on winning through litigation than attempting mediation because of the pain of a generally punitive reporting system.

Yee, *supra* note 3, at 430. Yee goes on to note that the fears concern not just removal of existing privileges, but an inability to gain privileges at new sites, or to gain entry to managed care organizations. *Id.* at 430 n.180.

⁸⁴ *Chudacoff v. Univ. Med. Ctr. of S. Nev.*, 609 F. Supp. 2d 1163, 1165 (D. Nev. 2009).

⁸⁵ *Id.* at 1166.

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had been denied or revoked because of the information listed on the NPDB.”⁸⁶ As the District of Nevada court observed, in finding that the hospital had not observed the procedural requisites of due process:

The private interest at stake here is the ability to practice medicine at a particular location. The interest extends further, however, in that a suspension of privileges at one hospital, when reported to the NPDB, could limit a physician’s ability to practice anywhere in the country. The amount of process must accord sufficient respect for a professional’s life and livelihood.⁸⁷

In *Doe v. Cmty Med. Ctr., Inc.*,⁸⁸ the Montana Supreme Court similarly held:

[W]e agree that Dr. Doe has demonstrated a likelihood of irreparable harm if CMC [Community Medical Center] is allowed to report his suspension prior to the resolution of the underlying merits of this case. . . . [A] ringing bell cannot be unringed. An erroneous report announcing to all interested parties that a physician is being investigated or suspended for unethical activity or impairment has the potential for immediate harm as well as permanent harm, even if later retracted.⁸⁹

⁸⁶ *Id.*

⁸⁷ *Id.* at 1173. The court went on:

Next, the risk of an erroneous deprivation is also significant, as an improper suspension would have dramatic consequences for the physician. Additionally, the NPDB only serves as a reliable source of information if it receives accurate reports; an erroneous report reduces the NPDB’s utility. As a result, there are substantial benefits to having procedural safeguards in place to protect both the physician and the NPDB from erroneous or improper reporting. Both are best served by having the safeguards in place on the front-end of the decision-making process; neither is served by remedial provisions. Once the damage is done, it is hard to undo.

⁸⁸ *Doe v. Cmty Med. Ctr. Inc.*, 221 P.3d 651 (Mont. 2009).

⁸⁹ *Id.* In a similar case, another Dr. Doe pointed out to the court, “Since hospitals must consult the NPDB every time a physician applies for clinical privileges or is placed on staff, that he could be denied privileges by a hospital on the basis of the information contained in the revised Report, which would result in yet another NPDB entry which would ‘reflect unfavorably upon him.’” *Doe v. Thompson*, 332 F. Supp. 2d 124, 127 (D.D.C. 2004).

*Cole v. St. James Healthcare*⁹⁰ featured a physician whose privileges had been restricted on grounds of allegedly inappropriate behavior. Noting the potential harm of a Data Bank entry, the Montana Supreme Court affirmed the lower court's restoration of privileges until the hospital could conduct a proper review in accordance with its own bylaws.⁹¹

To be sure, these examples concern a different sort of Data Bank entries than those discussed here—hospital credentialing decisions rather than medical malpractice payments. Nevertheless, physicians are reluctant to incur any sort of Data Bank entry, for reasons discussed just above.

B. Legal Options for Avoiding NPDB Reports

Although the Data Bank thus poses a significant deterrent to early resolution, physicians can in fact settle early and avoid a Data Bank report via a number of mechanisms.

1. Provider Pays Out of Pocket

Per HCQIA, “[e]ach *entity* (including an insurance company) which makes payment under a policy of insurance, self-insurance, or otherwise in settlement (or partial settlement) of, or in satisfaction of a judgment in, a medical malpractice action or claim shall report . . . information respecting the payment and circumstances thereof.”⁹² Although initially DHHS guidelines required that any payment made by a “person or entity” must be reported, this statutory interpretation was rejected by the D.C. Circuit Court

⁹⁰ *Cole v. St. James Healthcare*, 199 P.3d 810, 812 (Mont. 2008).

⁹¹ *Id.* at 815. The court noted the potential harm implicit in insufficient procedural protections:

If D. Cole is correct, and St. James has breached the Bylaws, the effects of the breach on Dr. Cole's reputation could be permanent. The District Court restored Dr. Cole to his status as an active staff member, restrained St. James from adopting the recommendation of the challenged Matovich investigation, and from taking any further adverse action on Dr. Cole's application. The court's injunction protects both Dr. Cole's patients and his professional reputation, at a minimal cost to St. James.

See also Elisabeth Ryzen, *The National Practitioner Data Bank—Problems and Proposed Reforms*, 13 J. LEGAL MED. 409, 444 n.189 (1992) (describing a Texas provision in which temporary medical licenses may not be issued to physicians whose NPDB report indicates medical malpractice payments, adverse licensure, or clinical privilege actions).

⁹² 42 U.S.C. § 11131(a) (2006) (emphasis added).

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of Appeals in 1993. In *Am. Dental Ass'n v. Shalala*, a dentist who had paid a malpractice claim out of pocket was reported to the Data Bank.⁹³ The dentist's efforts to remove that report were unsuccessful, and the District Court agreed with DHHS that any payment made by a person or entity must be reported to the NPDB.⁹⁴

The Circuit Court reversed, however, based on careful statutory analysis. If Congress's intent is clear, the court opined, there is no need to carry the analysis further.⁹⁵ And in this case Congress was quite clear:

[The HCQIA] reveals unmistakably that Congress did not intend to encompass any individual doctor or dentist as an "entity" that must report to the National Practitioner Data Bank. The Act does not define "entity," but the term as used in the Act refers uniformly to groups and organizations. ... [A]ll of the textual evidence points in one direction: Congress did not intend the term 'entity' to encompass individual practitioners. We find great significance in the fact that Congress chose to use only the term "entity" in setting out the requirement to report malpractice payments.⁹⁶

The Secretary of DHHS subsequently revised its guidelines, which now state quite clearly that practitioners' payments out of pocket do not require any report.⁹⁷

⁹³ *Am. Dental Ass'n v. Shalala*, 3 F.3d 445, 446 (D.C. Cir. 1993).

⁹⁴ *Id.* at 448.

⁹⁵ *Id.* at 446.

⁹⁶ *Id.* at 446-47.

⁹⁷ NPDB GUIDEBOOK, *supra* note 77, at E-10:

Individual subjects are not required to report payments they make for their own benefit to the NPDB. On August 27, 1993, the Circuit Court of Appeals for the District of Columbia held that ... the NPDB regulation requiring each 'person or entity' that makes a medical malpractice payment was invalid, insofar as it required individuals to report such payments. ... [I]f a practitioner or other person, rather than a professional corporation or other business entity, makes a medical malpractice payment out of personal funds, the payment is not reportable.

See also id. at E-16 ("Payment is made based only on oral demands. No report is required.").

2. *Waiver of Debt or Refund of Payment; Loss Adjustment Expenses*

A physician who forgives a patient's debt or refunds a prior payment need not report to the Data Bank: "A waiver of a debt is not considered a payment and should not be reported to the NPDB. For example, if a patient has an adverse reaction to an injection and is willing to accept a waiver of fee as settlement, that waiver is not reportable to the NPDB."⁹⁸

In a similar fashion, loss adjustment expenses (LAEs) such as attorney fees, expert witness fees, and copying fees need not be reported unless they are actually made part of a medical malpractice payment.⁹⁹

3. *Phone or Other Nonwritten Communication of Demand for Payment*

The key trigger requiring a report for a medical malpractice payment is "a written claim or demand for payment based on a health care provider's furnishing (or failure to furnish) health care services. . . ."¹⁰⁰ If a plaintiff or her attorney makes claim or demand for payment in a nonwritten form, such as by telephone or by direct person-to-person conversation, any money paid to settle that claim need not be reported.¹⁰¹ DHHS's NPDB Guidebook clarifies: "For purposes of NPDB reporting, medical malpractice payments are limited to exchanges of money. A refund of a fee is reportable only if it results from a *written* complaint or claim demanding monetary payment for

⁹⁸ *Id.* at E-12. *See also* 45 C.F.R. § 60.7(a) (2010) ("For purposes of this section, the waiver of an outstanding debt is not construed as a 'payment' and is not required to be reported."). *But c.f.* NPDB GUIDEBOOK, *supra* note 77, at E-12 ("[i]f a refund of a practitioner's fee is made by an entity (including solo incorporated practitioners), that payment is reportable to the NPDB.").

⁹⁹ NPDB GUIDEBOOK, *supra* note 77, at E-12. *See also id.* at E-31:

Question 15: "If there is no medical malpractice payment and Loss Adjustment Expenses (LAEs) are paid in order to release or dismiss a healthcare practitioner from a medical malpractice suit, should the LAE be reported?"

Answer: "No. If LAEs are not included in the medical malpractice payment, then they should not be reported to the NPDB."

¹⁰⁰ 42 U.S.C. § 11151(7) (2006).

¹⁰¹ NPDB GUIDEBOOK, *supra* note 77, at E-12.

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damages.”¹⁰² DHHS removes any lingering doubt in its question and answer examples:

Question 10: If a patient makes an oral demand for a refund for services, is the resulting payment reportable to the NPDB?

Answer: No. Only payments resulting from written demands are reportable to the NPDB. Even if the practitioner transmits the demand in writing to the medical malpractice payer, the payment is not reportable if the patient’s only demand was oral. However, if a subsequent written claim or demand is received from the patient and results in a payment, that payment is reportable.¹⁰³

Needless to say, plaintiffs who wish to pursue a claim by oral notification must be mindful about statutes of limitation, lest they be caught in a situation where oral negotiations fail sometime after the statute has run.

Just as plaintiffs and their attorneys can promote early resolution via oral rather than written notification of a potential suit, so can physicians initiate oral communication where they believe they may have erred or otherwise caused an adverse outcome. Just as many hospitals have discovered reductions in filed claims, time to settlement, and defense costs¹⁰⁴ physicians who attempt early resolution through nonwritten communication may be in a good position to achieve a settlement without incurring a Data Bank report.¹⁰⁵

4. *Contractual Agreement or Statutory Mandate for Pre-Suit Mediation*

Some institutions, such as Drexel University College of Medicine, invite patients to sign a voluntary mediation agreement.¹⁰⁶ By statute, South Carolina requires mediation prior to filing a medical malpractice claim:

¹⁰² *Id.* at E-12 (emphasis in original).

¹⁰³ *Id.* at E-31, Question 10.

¹⁰⁴ *See supra* Part IB.

¹⁰⁵ Somewhat analogously, a number of states have enacted statutes insulating physicians’ apologies and expressions of sympathy from being used as evidence if litigation later ensues—although such measures may not provide all the advantages their framers envisioned. *See generally* Mastroianni et al, *supra* note 39 at 1611–18; Marlynn Wei, *Doctors, Apologies, and the Law: An Analysis and Critique of Apology Laws*, 39 J. HEALTH LAW 107 (2007).

¹⁰⁶ *See* Yee, *supra* note 3, at 443 n.233; Christopher Guadagnino, *Malpractice Mediation Poised to Expand*, PHYSICIAN’S NEWS DIGEST (April 2004). To view the

Within ninety days and no later than one hundred twenty days from the service of the Notice of Intent to File Suit, the parties shall participate in a mediation conference unless an extension for no more than sixty days is granted by the court based upon a finding of good cause.¹⁰⁷

West Virginia does not mandate that parties mediate pre-suit, but does provide defendants with the option of requiring the plaintiff to mediate, once they have received pre-suit notification of plaintiff's intent to sue. A prospective physician-defendant thus can require pre-suit mediation.¹⁰⁸

In these cases where a written demand asks not for payment of money, but simply for a voluntary conversation whose usual purpose is to achieve a resolution while avoiding litigation, the plain language of the statute suggests that an NPDB report is not required. In other words, a written demand to *discuss* does not constitute a written demand for *payment*. If a settlement ensues, plain language further would imply that the money was not paid in response to a written claim or demand for payment.

5. High-Low Agreements

In some cases, parties wishing to limit risk will make an agreement prior to trial that, whatever the jury outcome, money will be paid within agreed

mediation agreement patients are invited to sign, see
<http://www.drexelmed.edu/documents/mediation/mediationagreement.pdf>. To view the
 pamphlet accompanying that agreement, see
http://www.drexelmed.edu/portals/1/NewMediationPatientBooklet-CHI_final_2_setp09_3_.pdf.

¹⁰⁷ S.C. CODE ANN. § 15-79-125(C) (2010). Of note, this mediation mandate accompanies a requirement that potential plaintiffs file a notice of intent to file a suit and an expert affidavit, after which parties may subpoena relevant documents. *See also* S.C. CODE ANN. § 15-79-120 (2010): "At any time before a medical malpractice action is brought to trial, the parties shall participate in mediation. . . . Parties may also agree to participate in binding arbitration, nonbinding arbitration, early neutral evaluation, or other forms of alternative dispute resolution." This latter version, unlike § 15-79-125, envisions a mediation taking place after, rather than before, the patient has actually filed suit. As discussed later in Part III, pre-trial settlement should not be confused with pre-suit settlement.

¹⁰⁸ "Upon receipt of the *notice* of claim or of the screening certificate of merit, if the claimant is proceeding pursuant to the provisions of subsection (d) of this section, the health care provider is entitled to pre-litigation mediation before a qualified mediator upon written demand to the claimant." W. VA. CODE § 55-7B-6(f) (Lexis 2008) (emphasis added). Pre-suit resolution will be discussed further in Part III, *infra*.

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parameters. Where the defendant practitioner prevails, she will not be reported even though money is paid. Per the NPDB Guidebook:

A “high-low” agreement, a contractual agreement between a plaintiff and a defendant’s insurer, defines the parameters of a payment the plaintiff may receive after a trial or arbitration proceeding. If the finder of fact returns a defense verdict, the defendant’s insurer agrees to pay the “low end” amount to the plaintiff. If the finder of fact returns a verdict for the plaintiff and against the defendant, the defendant’s insurer agrees to pay the “high end” amount to the plaintiff.

A payment made at the low end of a high/low agreement that is in place prior to a verdict or an arbitration decision would not be reportable to the NPDB *only* if the fact-finder rules in favor of the defendant and assigns *no liability to the defendant practitioner*. In this case, the payment is not being made for the benefit of the practitioner in settlement of a medical malpractice claim. Rather, it is being made pursuant to an independent contract between the defendant’s insurer and the plaintiff. ... *Note: in order for the low-end payment to be exempted from the reporting requirements, the fact finder must have made a determination regarding liability at the trial or arbitration proceeding.*¹⁰⁹

6. Corporate Shield

A well-recognized but somewhat more controversial avenue for resolving a medical malpractice claim without necessitating a Data Bank report has been dubbed the “corporate shield.” The NPDB Guidebook states that (1) where an entity such as a hospital or clinic makes a payment in a suit that does not identify an individual practitioner, no Data Bank report is

¹⁰⁹ NPDB Guidebook, *supra* note 77, at E-13 (emphasis in original). The Guidebook continues:

A payment made at the high end of the agreement is one made for the benefit of the practitioner and, therefore, must be reported to the NPDB. *When a defendant practitioner has been found to be liable by a fact-finding authority, such as a judge, a jury, or by arbitration, any payment made pursuant to that finding must be reported, regardless of the existence of a high-low agreement.*

If a high-low agreement is in place, and the plaintiff and defendant settle the case prior to trial, the existence of the high-low agreement does not alter the reportability of the settlement payment.

Id.

required¹¹⁰ and (2) where a practitioner is dismissed from a lawsuit prior to the settlement or judgment, no report need be made.¹¹¹

In essence:

the corporate shield refers to the situation where the medical corporation for which the doctor works is named in the suit, and the doctor is either not originally named or is released specifically for the purpose of avoiding a report to the NPDB. There is evidence that some insurers will 'cut a deal' with the plaintiff's attorney to dismiss the doctor from the suit and let the payment be made entirely on behalf of the corporation, hospital, or other entity.¹¹²

By the mid-1990s, somewhere around 50% of otherwise-required NPDB reports were thought to be diverted via the corporate shield.¹¹³

¹¹⁰ "A payment made as a result of a suit or claim solely against an entity (for example, a hospital, clinic, or group practice) and that does not identify an individual practitioner is not reportable under the NPDB's current regulations." *Id.* at E-8.

In order for a particular physician, dentist, or other health care practitioner to be named in an MMPR submitted to the NPDB, the practitioner must be named in both the written complaint or claim demanding monetary payment for damages and the settlement release or final adjudication, if any. Practitioners named in the release, but not in the written demand or as defendants in the lawsuit, are not reportable to the NPDB. A practitioner named in the written complaint or claim who is subsequently dismissed from the lawsuit and not named in the settlement release is not reportable to the NPDB.

Id. at E-11.

¹¹¹ As the NPDB Guidebook notes:

A payment made to settle a medical malpractice claim or action is not reportable to the NPDB if the defendant health care practitioner is dismissed from the lawsuit *prior* to the settlement or judgment. However, if the dismissal results *from a condition in the settlement or release*, then the payment is reportable. In the first instance, there is no payment for the benefit of the health care practitioner because the individual has been dismissed from the action *independently* of the settlement or release. In the latter instance, if the practitioner is dismissed from the lawsuit *in consideration* of the payment being made in settlement of the lawsuit, the payment can only be construed as a payment for the benefit of the health care practitioner and must be reported to the NPDB.

Id. at E-12–13.

¹¹² Smarr, *supra* note 64, at 67.

¹¹³ *Id.*

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DHHS has long recognized this phenomenon and, over time, has considered whether to limit its use.¹¹⁴ A GAO study in 2000 expressly acknowledged DHHS's ambivalence, given that a significant change in these rules could "interfere with settlement negotiations between the insurer and the claimant."¹¹⁵

¹¹⁴ John F. Bales III, *Medical Malpractice Developments*, in PRACTISING LAW INSTITUTE 1994, AT 563, 625–26 (PLI COMMERCIAL LAW & PRACTICE, COURSE HANDBOOK SER. NO. 700, 1994).

¹¹⁵ Per the GAO report:

Soon after NPDB began operating in 1990, HRSA officials became aware that under the data bank's regulations, some practitioners, who may have committed malpractice, were not being reported because of what has become known as the "corporate shield." NPDB regulations require that only the practitioners named in final malpractice settlements be reported to the data bank. The corporate shield occurs when individuals filing malpractice claims remove the practitioner's name from the claim, leaving only the hospital or another corporate entity identified as the responsible party. When this happens, no report is submitted to NPDB. HRSA officials believe that practitioners who have committed malpractice use the corporate shield to avoid being reported. However, they have not been able to quantify the extent to which the corporate shield is used for such purposes. In addition, the agency has not found a means of successfully addressing this issue in a way that would also have the support of industry representatives on NPDB's Executive Committee, who could facilitate compliance by persuading member organizations to adopt this policy change.

In December 1998, HRSA proposed changing NPDB's malpractice payment reporting regulations. The proposal would have required that insurers report all practitioners for whose benefit a payment is made, including those practitioners who might not have been named in the final settlement or even in the initial malpractice claim. The health care industry—including those organizations on NPDB's Executive Committee—overwhelmingly opposed the proposal, arguing that it would interfere with settlement negotiations between the insurer and the claimant. The industry also argued that reporting all initially named practitioners would deny due process to those not found liable by the court. HRSA subsequently withdrew the proposal and initiated other strategies to solve this problem while working to gain NPDB Executive Committee support for a change in medical malpractice reporting requirements.

U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-01-130, NAT'L PRACTITIONER DATA BANK: MAJOR IMPROVEMENTS ARE NEEDED TO ENHANCE DATA BANK'S RELIABILITY, at 11 (2000), *available at* <http://www.gao.gov/new.items/d01130.pdf>.

See also U.S. DEP'T OF HEALTH AND HUMAN SERVS., NAT'L PRACTITIONER DATA BANK: 2005 ANNUAL REPORT at 30, *available at* <http://www.npdb-hipdb.hrsa.gov/resources/reports/2005NPDBAnnualReport.pdf> [hereinafter "NPDB 2005 Annual Report"]:

Notwithstanding episodic controversies regarding the corporate shield, it has proved to be an important asset in current efforts to promote early dispute resolution and to focus on addressing injured patients' and families' goals and needs while emphasizing broad communication that can better improve safety and quality of care.¹¹⁶

The University of Michigan Health System avowedly uses the corporate shield, and its settlements are generally in the institution's name. UMHS is a staff-model institution in which physicians are employees rather than independent contractors, hence under this approach "reporting of individual caregivers in medical malpractice claims in the National Practitioner Data Bank is rare. However, full claims histories are maintained and reported for each involved caregiver, as required."¹¹⁷ In other words, UMHS emphasizes thorough internal peer review as part of its overall quality process. Even though it rarely reports medical malpractice payments, it still actively reports adverse actions on a provider's privileges or credentials to the NPDB.¹¹⁸

Further discussion of the "moral hazard" issues that arise when providers systematically avoid making Data Bank reports via these exceptions will be taken up in Part IV. Suffice it here to say that rapid changes in the current health care market make possible a significantly greater use of the corporate

"Corporate Shield" may mask the extent of substandard care and diminish NPDB's usefulness as a flagging system: Malpractice payment reporting may be affected by use of the "corporate shield." Attorneys have worked out arrangements in which the name of a health care organization (e.g., a hospital or group practice) is substituted for the name of the practitioner, who would otherwise be reported to the NPDB. This is most common when the health care organization is responsible for the malpractice coverage of the practitioner. Under current NPDB regulations, if a practitioner is named in the claim but not in the settlement, no report about the practitioner is filed with the NPDB unless the practitioner is excluded from the settlement as a condition of the settlement.

See also U.S. DEP'T OF HEALTH AND HUMAN SERVS., NAT'L PRACTITIONER DATA BANK: 2006 ANNUAL REPORT, at 34, available at <http://www.npdb-hipdb.hrsa.gov/resources/reports/2006NPDBAnnualReport.pdf> [hereinafter "NPDB 2006 Annual Report"]. Of note, the most recent NPDB Annual Report does not discuss corporate shield issues. *See* U.S. DEP'T OF HEALTH AND HUMAN SERVS., NAT'L PRACTITIONER DATA BANK COMBINED ANNUAL REPORT 2007, 2008, AND 2009, issued September 2011, available at <http://www.npdb-hipdb.hrsa.gov/resources/reports/2007-08-09NPDBAnnualRep.pdf> [hereinafter NPDB 2007-2009 Annual Report].

¹¹⁶ *See* Kachalia et al., *supra* note 45, at 214. UMHS tries to emphasize "honesty and transparency with patients and staff, regardless of whether events resulted from error, and encourages staff to enlist risk management in the disclosure process." *Id.*

¹¹⁷ *Id.* at 214.

¹¹⁸ *Id.*

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shield, with the emergence of Accountable Care Organizations, bundled payment arrangements, hospital purchases of physician practices, and other structures that may make it more attractive and appropriate for hospitals and other entities to provide “enterprise liability.”¹¹⁹ To the extent that the corporate shield remains permissible, and to the extent it becomes increasingly utilized by complex provider structures, physicians can find expanding opportunities to participate in early mediation of health care disputes without incurring a permanent black mark in the Data Bank.

7. Pre-Suit Notification Period

Finally, a number of states have enacted statutes mandating that, before the plaintiff is permitted to file a medical malpractice claim, he or she must provide advance notification to the defendant. Although these notices must generally be in writing and may require considerable specificity, arguably they do not constitute a “written claim or demand for payment,” but rather, simply an alert that in the future there will likely be such a claim. If so, then payments made during the pre-suit notification period would not be reportable. These statutes are the focus of Part III.

III. PRE-SUIT NOTIFICATION STATUTES AND NPDB REPORTS

A. Statute Characteristics

In recent years a number of states have enacted legislation requiring plaintiffs to provide defendants with advance notice of their intent to file a

¹¹⁹ Mark C. Shields, Jankaj H. Patel, Martin Manning & Lee Sacks, *A Model for Integrating Independent Physicians into Accountable Care Organizations*, 30 HEALTH AFFAIRS 1 (2011); Paul R. DeMuro, *Community Physicians Participating in Accountable Care Organizations through Clinical Integration*, 22 THE HEALTH LAWYER 13 (2010); Thomas L. Greaney, Anna D. Sinaiko & Meredith B. Rosenthal, *Accountable Care Organizations—The Fork in the Road*, 263 NEW ENGL. J. MED. e1 (2011). See also William M. Sage & JM Jorling, *A World That Won't Stand Still: Enterprise Liability by Private Contract*, 43 DEPAUL LAW REV. 1007 (1994); William M. Sage, *Enterprise Liability and the Emerging Managed Health Care System*, 60 LAW & CONTEMP. PROBS. 159 (1997); *Patients' Role in Accountable Care Organizations*, 363 NEW ENGL. J. MED. 2583 (2011); see also, e.g., Jeroen N. Struijs & Caroline A Baan, *Integrating Care Through Bundled Payments—Lessons from the Netherlands*, 364 NEW ENGL. J. MED. 990 (2011); Avery Johnson, *The Model of the Future? The Health-Care Law Promoted Accountable-Care Organizations. But It's Hard to Know What They Are*, WALL ST. J. (March 28, 2011), at R6.

medical malpractice claim. West Virginia requires thirty days' notice,¹²⁰ for instance, while Tennessee, Texas, and Mississippi each require sixty days.¹²¹ States requiring ninety days include Utah, Florida, California, and the District of Columbia.¹²² Somewhat indirectly, Louisiana¹²³ and South Carolina¹²⁴ also set 90 days. Michigan provides the longest pre-suit notice period, at 182 days.¹²⁵ Three states have either repealed a pre-suit notice statute¹²⁶ or have seen it judicially overturned.¹²⁷

These statutes share the same basic purposes: "to promote settlement without the need for formal litigation and reduce the cost of medical malpractice litigation while still providing compensation for meritorious medical malpractice claims that might otherwise be precluded from recovery because of litigation costs."¹²⁸ "The purpose of an intent to sue notice is to

¹²⁰ W. VA. CODE § 55-7B-6(b) (Lexis 2008); *see also* 55-7B-6(f) (2010) ("provider may be entitled to pre-litigation mediation upon written demand to claimant").

¹²¹ TENN. CODE ANN. § 29-26-121(a)(1) (2011); TEX. CIV. PRAC. & REM. CODE ANN. (WEST 2011) § 74.051(a); MISS. CODE ANN. § 15-1-36(15) (2011).

¹²² UTAH CODE ANN. § 78B-3-412 (West 1953); FLA. STAT. ANN. § 766.106(2), (3)(a) (West 2007); CAL. CIV. PROC. CODE § 364(a); D.C. CODE § 16-2802 (2011).

¹²³ LA. REV. STAT. ANN. § 40:1299.47(A)(1)(a), (2)(a), (B)(1) (stating medical malpractice claims must begin with request for review panel, which then suspends for 90 days the time within which suit must be filed).

¹²⁴ S.C. CODE ANN. § 15-79-125 (requiring notice of intent to be followed by mediation in 90-120 days; suit may not be filed until after mediator determines impasse exists or mediation should end, within 60 days thereafter).

¹²⁵ MICH. COMP. LAWS ANN. § 600.2912b.

¹²⁶ VA. CODE ANN. § 8.01-581.2 (2011) (*repealed by statute*); *see* Harris v. DiMattina, 462 S.E.2d 338 (Va. 1995).

¹²⁷ *See* Waples v. Yi, 234 P. 3d 187 (Wash. 2010) (ruling Washington statute RCW 7.70.100(1) (2006) unconstitutional as a violation of separation of powers); Carson v. Maurer, 424 A.2d 825 (N.H. 1980) (ruling New Hampshire statute N.H. Rev. Stat. § 507 C:5 unconstitutional as violating equal protection). *But see, e.g.,* Thomas v. Warden, 999 So. 2d 842, 847 (Miss. 2008); Wimley v. Reid, 991 So. 2d 135, 137-38 (Miss. 2008); Pearlstien v. Malunney, 500 So. 2d 585, 586 (Fla. Dist. Ct. App. 1896), *rev. denied*, 511 So. 2d 299 (Fla. 1987) (expressly upholding the constitutionality of pre-suit notification); Neal v. Oakwood Hosp. Corp., 575 N.W.2d 68, 76 (Mich. Ct. App. 1997); Waples v. Yi, 234 P. 3d 192 (Wash. 2010) (Johnson, J., dissenting).

¹²⁸ *Oakwood Hosp. Corp.*, 575 N.W.2d at 71, 75; *see also* DeCosta v. Gossage, 782 N.W. 2d 734, 735 (Mich. 2010) (stating that it is in the furtherance of justice to disregard any error or defect ... to promote settlement in the place of formal litigation).

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give the parties an opportunity to discuss, and hopefully to resolve, the potential claim before they become locked into a lawsuit.”¹²⁹

At this point the question arises whether any payments an insurer makes on a physician’s behalf during this pre-suit period must be reported to the Data Bank. If these payments must be reported the same as when the plaintiff has formally filed suit, these statutes’ objectives will be largely upended. If physicians still need to avoid a permanent “black mark” in the NPDB at this early point, then they will still have the same motivation to abjure early mediation and hold out for victory at trial.

B. Insurer Concerns

As it happens, some medical malpractice insurers do report a settlement made during this pre-suit period. There are several reasons.

First, some of these statutes require a fair amount of information to be provided with the pre-suit notice of intent, so that the notice looks rather like a filed claim. South Carolina, for instance, requires that the pre-suit notice “must name all adverse parties as defendants, must contain a short and plain statement of the facts showing that the party filing the notice is entitled to relief, must be signed by the plaintiff or by his attorney, and must include any standard interrogatories or similar disclosures required by the South Carolina Rules of Civil Procedure.”¹³⁰ The notice must ordinarily be in writing and must be delivered in specified ways.¹³¹

¹²⁹ Behrens v. Raleigh Hills Hosp., Inc., 675 P.2d 1179, 1183 (Utah 1983). *See also* Jenkins v. Marvel, 683 F. Supp. 2d 626, 639 (E.D. Tenn. 2010); Hill v. Russell, 247 S.W.3d 356, 360 (Tex. Ct. App. 2008); Hinchman v. Gillette, 618 S.E.2d 387, 393–94 (W. Va. 2005) (stating that the purpose of a notice of intent to sue is to give the defendant notice of the incident in order to allow investigation of the matter and promote pre-suit settlement of the claim); Weinstock v. Groth, 629 So. 2d 835, 838 (Fla. 1993) (stating that the purpose of the Chapter 766 pre-suit requirements is to alleviate the high cost of medical negligence claims through early determination and prompt resolution of claims, not to deny access to the courts to plaintiffs); Solimando v. Int’l Med. Ctrs., 544 So. 2d 1031, 1034 (Fla. Dist. Ct. App. 1989); Schepps v. Presbyterian Hosp. of Dallas, 652 S.W.2d 934, 938 (Tex. 1983).

¹³⁰ S.C. CODE ANN. § 15-79-125(A) (2010).

¹³¹ West Virginia requires certified mail, return receipt requested. W. VA. CODE § 55-7B-6(b) (Lexis 2008). Tennessee requires written notice to each prospective defendant and requires that it be mailed both to the provider’s current business address and to the address listed with the state’s department of health. TENN. CODE ANN. § 29-26-121(a)(1) (2010); TENN. CODE ANN. § 29-26-121(a)(3)(B) (2010). *See also, e.g.,* MICH. COMP. LAWS. ANN. § 600.2912b(2) (WEST 2003); UTAH CODE ANN. § 78B-3-412(3) (West

Michigan, similarly, requires that the notice state:

- (a) The factual basis for the claim.
- (b) The applicable standard of practice or care alleged by the claimant.
- (c) The manner in which it is claimed that the applicable standard of practice or care was breached by the health professional or health facility.
- (d) The alleged action that should have been taken to achieve compliance with the alleged standard of practice or care.
- (e) The manner in which it is alleged the breach of the standard of practice or care was the proximate cause of the injury claimed in the *notice*.
- (f) The names of all health professionals and health facilities the claimant is notifying under this section in relation to the claim.¹³²

The trigger mandating a report to the Data Bank is a “written claim or demand for payment”¹³³ If these notices must be written, and if in all this detail they can be interpreted as a demand for payment, then insurers may infer it best to be on the “safe” side, and report any pre-suit settlement payment.

Second, and again analogous to litigation, some states provide that informal discovery should take place following such pre-suit notice. Florida, for instance, requires that “[u]pon receipt by a prospective defendant of a notice of claim, the parties shall make discoverable information available without formal discovery. Failure to do so is grounds for dismissal of claims or defenses ultimately asserted.”¹³⁴ Potential litigants may then obtain unsworn statements, medical records, documents and things, mental and physical examinations and other information useful for determining whether litigation should ultimately proceed.

Third, insurers point out that once the pre-suit notice is issued and the parties express interest in mediation, parties may well exchange written proposals to establish “ballpark” monetary settlement figures prior to the actual mediation. Perhaps these should be construed as written demands, an insurer might suppose.

Fourth, actual notice letters from plaintiff attorneys sometimes—perhaps commonly—move quickly from the language of “potential claim” to the

1953); FLA. STAT. ANN. § 766.106(2)(a) (WEST 2007); TEX. CIV. PRAC. & REM. CODE ANN. § 74.051(a) (West 2009).

¹³² MICH. COMP. LAWS ANN. § 600.2912b(4) (WEST 2003).

¹³³ 42 U.S.C. § 11151(7) (2006).

¹³⁴ FLA. STAT. ANN. § 766.106(6)(a) (West 2007).

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language of “claim.” See Figures 1-4.¹³⁵ If the attorney herself calls it a claim, then insurers may infer that perhaps it really is a claim and must be treated as such, for NPDB reporting purposes.

Dear [REDACTED]

I am the attorney representing [REDACTED] and [REDACTED] [REDACTED] next of kin. Through me and my firm, [REDACTED] is asserting a potential claim for medical malpractice against your professional corporation. This claim arises out of care provided by employees, shareholders, members, and/or agents, of [REDACTED], [REDACTED], and by other individuals acting on behalf of [REDACTED]

Figure 1: “potential claim” in the second sentence becomes “claim” in the third sentence.

Dear [REDACTED]

I am the attorney representing [REDACTED], the legal representative of [REDACTED] [REDACTED]. Through me and my firm, [REDACTED] is asserting a potential claim for medical malpractice against you. This claim arises out of care provided by you to your patient, [REDACTED], at [REDACTED] on or about [REDACTED]

Figure 2: “potential claim” becomes “claim.”

Dear [REDACTED]

I am the attorney representing the surviving family members of [REDACTED] [REDACTED]. Through me and my firm, the family members are asserting a potential claim for medical malpractice against you. This claim arises out of care provided by you to your patient, [REDACTED] at the home municipally known as [REDACTED] on or about [REDACTED]

Figure 3: “potential claim” becomes “claim.”

¹³⁵ Letter excerpts provided here are genuine pre-suit notifications, although names have been redacted to preserve confidentiality.

Dear [REDACTED] and To Whom It May Concern:

Please be advised that [REDACTED] and [REDACTED] are hereby giving [REDACTED] ([REDACTED]) written notice, pursuant to Tenn. Code Ann. § 29-26-121, that a medical malpractice claim may be filed against it within the time period required by law based upon the medical negligence of [REDACTED] acting through its principals, agents, employees, doctors, and nurses, in rendering care and treatment to [REDACTED] beginning in [REDACTED]. This claim relates to personal injuries sustained by [REDACTED] and loss of consortium damages sustained by [REDACTED]. The medical malpractice claim will be filed by [REDACTED].

Figure 4: “claim may be filed” becomes “this claim” and “[t]he medical malpractice claim.”

The answer to this last concern seems obvious. Plaintiff attorneys should consistently avoid using “claim” without an appropriate qualifier such as “potential” or “possible.” Even with this fix, however, we must still consider insurers’ other three concerns, namely, that these notices are in writing, that they may feature elements that strongly resemble a classic medical malpractice claim, and that written monetary proposals may be exchanged before and during mediation.

C. Data Bank Report: Arguably Not Required During Pre-Suit Notification Period

Several arguments support the conclusion that, notwithstanding the superficial resemblance between a filed malpractice suit and a pre-suit notice, a monetary payout made after a pre-suit notice but prior to a filed claim does not require a Data Bank report.

First we must look to the plain language of the federal statute and to the plain language of the various state statutes. Plain language figured prominently in the only appellate case reasonably on point. As discussed above, in *Am. Dental Ass’n v. Shalala*, the D.C. Circuit Court of Appeals invoked an extensive plain-language analysis to find that an “entity” paying on behalf of a practitioner does not encompass an individual person.¹³⁶

¹³⁶ *Am. Dental Ass’n v. Shalala*, 3 F.3d at 445. See *supra* Part II-B-1. Per HCQIA, “[e]ach entity (including an insurance company) which makes payment under a policy of insurance, self-insurance, or otherwise in settlement (or partial settlement) of, or in satisfaction of a judgment in, a medical malpractice action or claim shall report ...” 42 U.S.C. § 11131(a) (2006).

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Therefore, the court concluded, a practitioner need not report out-of-pocket payments to the Data Bank. Per the court, the HCQIA:

reveals unmistakably that Congress did not intend to encompass any individual doctor or dentist as an “entity” that must report to the National Practitioner Data Bank. The Act does not define “entity” but the term as used in the Act refers uniformly to groups and organizations. ... [A]ll of the textual evidence points in one direction: Congress did not intend the term “entity” to encompass individual practitioners.¹³⁷

Five years later the D.C. district court likewise undertook careful analysis of the statute’s plain language regarding what counts as and “investigation” by an “institution,” to conclude that a Data Bank report should not have been made in a case where a few senior members of a surgery department began monitoring a surgeon colleague’s performance.¹³⁸

Here, as we consider pre-suit notices, HCQIA’s language requires that an entity such as an insurer file a report when it makes payment on a physician’s behalf in connection with a medical malpractice action or claim.¹³⁹ A “medical malpractice action or claim,” in turn, is a “written claim or demand for payment based on a health care provider’s furnishing (or failure to furnish) health care services”¹⁴⁰ Thus, we must parse carefully the words “written claim or demand for payment.” As noted above, DHHS already recognizes that the statute must be read precisely as it is written, as it concedes, e.g., that an *oral* claim or demand for payment will not trigger a Data Bank report¹⁴¹ because it is not “written.” Accordingly, our question is whether a pre-suit notice constitutes a “written claim or demand for payment.”

A brief review of the relevant state statutes suggests that, under a plain language analysis, these notices do not. Although written, these notices are not a “claim or demand *for payment*.” Rather, they are a notification about a potential, future claim or demand. Michigan, for instance, mandates that “a

¹³⁷ *Id.* at 446–47.

¹³⁸ *Simpkins v. Shalala*, 999 F. Supp. 106, 114 (D.D.C. 1998). Somewhat in contrast, a Kentucky court found that, under a significantly different fact pattern, a bona fide investigation had been commenced by an institution, thereby requiring a Data Bank report. *See Omar v. Jewish Hosp. Healthcare Servs.*, 153 S.W.3d 845, 846 (Ky. Ct. App. 2005).

¹³⁹ 42 U.S.C. § 11131(a) (2006).

¹⁴⁰ 42 U.S.C. § 11151(7) (2006).

¹⁴¹ NPDB Guidebook, *supra* note 77, at E-16 (“Payment is made based only on oral demands. No report is required.”).

person shall not commence an action alleging medical malpractice against a health professional . . . unless the person has given . . . written notice under this section not less than 182 days *before the action is commenced*.”¹⁴² In other words, a written claim or demand for payment cannot be made unless the prior notice mandate has first been satisfied.

Tennessee emphasizes that this notice describes a “potential claim”¹⁴³ and expressly states that the notice must be provided “before the filing of a complaint.”¹⁴⁴ Texas’ statute provides similar wording.¹⁴⁵ Mississippi and California both use the comparable language of “*prior* written notice” or “*prior* notice of the intention.”¹⁴⁶ Plain language says that a “potential” claim is merely a possibility of a future claim—not an actual present demand, and that a notice which must be sent *before* a complaint can be filed can not, itself, be that complaint.

Indeed, a number of states have expressly dubbed their required pre-suit notification a “condition precedent” to filing a claim. Again, plain language suggests that a condition precedent to a filed claim can not, itself, be such a claim. Thus, the Mississippi Supreme Court held in *Wimley v. Reid*¹⁴⁷ that “pre-suit requirements are clearly within the purview of the Legislature, and do not encroach upon this Court’s rulemaking responsibility. Indeed, we consistently have held that the Legislature has authority to establish pre-suit requirements as a condition precedent to filing particular kinds of

¹⁴² MICH. COMP. LAWS. ANN. § 600.2912b(1) (2003) (emphasis added).

¹⁴³ TENN. CODE ANN. § 29-26-121(a)(1) (2011): “Any person, or that person’s authorized agent, asserting a *potential claim* for medical malpractice shall give written notice of the potential claim to each health care provider that will be a named defendant at least sixty (60) days *before the filing of a complaint* based upon medical malpractice in any court of this state” (emphasis added).

¹⁴⁴ *Id.* at § 29.

¹⁴⁵ TEX. CIV. PRAC. & REM. § 74.051(a)ii (2009) “Any person or his authorized agent asserting a health care liability claim shall give written notice of such claim. . . . to each physician or health care provider against whom such claim is being made at least 60 days *before the filing of a suit* in any court of this state based upon a health care liability claim” (emphasis added).

¹⁴⁶ MISS. CODE ANN. § 15-1-36(15) (2010) (“No action based upon the health care provider’s professional negligence may be begun unless the defendant has been given at least sixty (60) days’ *prior written notice of the intention to begin the action*”) (emphasis added); CAL. CIV. PROC. CODE § 364 (a) (2011) (“No action based upon the health care provider’s professional negligence may be commenced unless the defendant has been given at least 90 days’ *prior* notice of the *intention* to commence the action”) (emphasis added).

¹⁴⁷ *Wimley*, 991 So. 2d at 139. See also *Warden*, 999 So. 2d at 847.

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lawsuits.”¹⁴⁸ Similarly, the Florida Supreme Court has held that “[t]imely written notice of intent to initiate litigation is a condition precedent to maintaining a medical malpractice action.”¹⁴⁹

Additionally, some states have expressly stated that a pre-suit notice is not the same thing as a malpractice complaint. Per the Utah Supreme Court:

A notice of intent to sue, as required by U.C.A., 1953, § 78-14-8, is not intended to be the equivalent of a complaint and need not contain every allegation and claim set forth in the complaint. The purpose of an intent to sue notice is to give the parties an opportunity to discuss, and hopefully to resolve, the potential claim before they become locked into a lawsuit. Although the notice must include “specific allegations of misconduct on the part of the prospective defendant,” that requirement does not need to meet the standards required to state a claim for relief in a complaint. The parties need to give only general notice of an intent to sue and of the injuries then known and not a statement of legal theories.¹⁵⁰

Likewise, Florida has expressly stated that the informal discovery of pre-suit negotiations must be assured confidentiality, so as to distinguish these exchanges of information from the formal discovery of a medical malpractice action.¹⁵¹

Similarly, the state of Louisiana requires all malpractice claims initially to be presented to a medical review panel for pre-litigation screening. Louisiana statute stipulates that this request can not be reported to the state

¹⁴⁸ *Wimley*, 991 So. 2d at 139.

¹⁴⁹ *Patry v. Capps*, 633 So. 2d 9, 11 (Fla. 1994). *See also Oakwood Hosp. Corp.*, 575 N.W.2d at 74; *Ingersoll v. Hoffman*, 589 So. 2d 223, 224–25 (Fla. 1991); *Hosp. Corp. of Am. v. Lindberg*, 571 So. 2d 446, 448 (Fla. 1990); *Foil v. Ballinger*, 601 P.2d 144, 146 (Utah 1979).

¹⁵⁰ *Raleigh Hills Hosp., Inc.*, 675 P.2d at 1183 (§ 78-14-8 now renumbered as § 78B-3-412 by Laws 2008, c. 3, § 718, eff. Feb. 7, 2008).

¹⁵¹

In order to distinguish non-meritorious negligence claims at the earliest point, a free and open exchange of information during the pre-suit screening process is necessary and this is more likely to occur if parties are assured confidentiality of information. For all of these reasons, the legislature distinguished between informal and formal discovery in a medical malpractice action, *see* FLA. STAT. § 766.106(6), (2007), and made it clear that information obtained during pre-suit screening is confidential and not subject to formal discovery.

Variety Children’s Hosp. v. Boice, 27 So. 3d 788, 790 (Fla. Dist. Ct. App. 2010).

licensing board or any other supervisory body, whereas actual malpractice claims do require such reporting:

The filing of a request for review by a medical review panel as provided for in this Section shall not be reportable by any health care provider, the Louisiana Patient's Compensation Fund, or any other entity to the Louisiana State Board of Medical Examiners, to any licensing authority, committee, or board of any other state, or to any credentialing or similar agency, committee, or board of any clinic, hospital, health insurer, or managed care company.¹⁵²

Similar mandates for confidentiality cover mediations and, hence, address another potential reason why an insurer might feel a need to report a pre-suit settlement to the NPDB. Mediations commonly involve written pre-mediation statements that may, indeed, feature proposed settlement terms. Additionally, intra-mediation negotiations will likewise bandy numbers about. Typically at least some of these are in writing, and might therefore be thought of as a written claim or demand.

Nevertheless, such jottings should not be deemed a written claim or demand for payment under HCQIA. First, mediation by nature does not feature a "demand" in the relevant sense. Parties of course make proposals but, because any resolution is completely voluntary and is undertaken as an alternative to litigation, mediation proposals do not constitute the kind of "claim" or "demand" contemplated by HCQIA.

More importantly, strong confidentiality provisions generally protect mediation proceedings in all phases. For one thing, federal and many states' rules of evidence provide that offers to settle or to compromise are not admissible if litigation later ensues. Per Federal Rule of Evidence 408, *Compromise and Offers to Compromise*:

(a) Prohibited uses. Evidence of the following is not admissible on behalf of any party, when offered to prove liability for, invalidity of, or amount of a claim that was disputed as to validity or amount, or to impeach through a prior inconsistent statement or contradiction:

(1) furnishing or offering or promising to furnish or accepting or offering or promising to accept a valuable consideration in compromising or attempting to compromise the claim; and

¹⁵² LA. REV. STAT. ANN. § 40:1299.47(A)(1)(a) (2008).

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(2) conduct or statements made in compromise negotiations regarding the claim ...¹⁵³

Many states have comparable rules. Moreover, states and the federal government also provide specific protections expressly for mediation. Tennessee, for instance, mandates a thoroughgoing confidentiality in its Supreme Court Rule 31: “Rule 31 Neutrals shall preserve and maintain the confidentiality of all information obtained during Rule 31 ADR Proceedings and shall not divulge information obtained by them during the course of Rule 31 ADR Proceedings without the consent of the parties, except as otherwise may be required by law.”¹⁵⁴ Mediation confidentiality is also protected in

¹⁵³ The rule goes on, in (b), to say: “Permitted uses. This rule does not require exclusion if the evidence is offered for purposes not prohibited by subdivision (a). Examples of permissible purposes include proving a witness’s bias or prejudice; negating a contention of undue delay; and proving an effort to obstruct a criminal investigation or prosecution.”

¹⁵⁴ TENN. SUP. CT. R. 31 § 10(d). *See also* TENN. SUP. CT. R. 31 A, § 7:

Confidentiality

(a) Required

A Neutral shall preserve and maintain the confidentiality of all dispute resolution proceedings except where required by law to disclose information.

(b) When Disclosure Permitted

A Neutral conducting a Rule 31 Mediation shall keep confidential from the other parties any information obtained in individual caucuses unless the party to the caucus permits disclosure.

(c) Records

A Neutral shall maintain confidentiality in storing or disposing of records and shall render anonymous all identifying information when materials are used for research, training, or statistical compilations.

See also Ala. Code of Ethics for Mediators Std. 6: “(a) *Confidentiality*. A mediator shall preserve and maintain the confidentiality of all mediation proceedings except where required by law to disclose information gathered during the mediation.”

See also OR. REV. STAT. § 36.262 (1989):

(1) All memoranda, work products and other materials contained in the case files of a mediator or mediation service are confidential. Any communication made in, or in connection with, the mediation which relates to the controversy being mediated, whether made to the mediator or a party, or to any other person if made at a mediation session, is confidential. However, a mediated agreement shall not be confidential unless the parties otherwise agree in writing. (2) Confidential materials and communications are not subject to disclosure in any judicial or administrative proceeding except: (a) When all parties to the mediation agree, in writing, to waive the confidentiality; (b) In a subsequent action between the mediator and a party to

federal rules of court.¹⁵⁵

Although such protections often feature a caveat permitting disclosure if “otherwise . . . required by law,” at no point does HCQIA require disclosure of mediation negotiations.

Moreover, HCQIA’s definition of a “medical malpractice action or claim” does not appear to include the informal conversations and proceedings of mediation. The Act illustrates its definition of a “written claim or demand for payment” by saying that a malpractice action or claim “includes the filing of a cause of action, based on the law of tort, brought in any court of any State or the United States seeking monetary damages.”¹⁵⁶ Similarly, the Code of Federal Regulations states such a malpractice claim “includes the filing of a cause of action based on the law of tort, brought in any State or Federal Court or other adjudicative body.”¹⁵⁷ The emphasis on formal filings with adjudicative bodies thus lends further credence to the conclusion that private mediation negotiations will not be deemed written claims or demands for Data Bank reporting purposes.

In sum, there appears to be no persuasive argument that a pre-suit notice of intent to file a claim should, itself, be treated as a written claim or demand for purposes of Data Bank reporting.

Plain language suggests that such notices are not themselves a demand for payment, but rather are simply a written note indicating that a demand for payment may—or may not—be forthcoming. Indeed, the notice itself does not demand payment of any kind. It simply outlines some features of the demand that might or might not eventually be made, thereby permitting

the mediation for damages arising out of the mediation; or (c) Statements, memoranda, materials and other tangible evidence, otherwise subject to discovery, that were not prepared specifically for use in and actually used in the mediation.

¹⁵⁵ See, e.g., U.S. DIST. CT. RULES N.D.CA., ADR L.R. 6-12:

(a) Confidential Treatment. Except as provided in subdivision (b) of this local rule, this court, the mediator, all counsel and parties, and any other persons attending the mediation shall treat as “confidential information” the contents of the written Mediation Statements, anything that happened or was said, any position taken, and any view of the merits of the case expressed by any participant in connection with any mediation. “Confidential information” shall not be: (1) disclosed to anyone not involved in the litigation; (2) disclosed to the assigned judge; or (3) used for any purpose, including impeachment, in any pending or future proceeding in this court.

¹⁵⁶ 42 U.S.C. § 11151(7) (2006).

¹⁵⁷ 45 C.F.R. § 60.3 (2010).

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parties a relatively detailed picture of the issues they may wish to resolve early.

Finally, the whole point of these statutes is substantially defeated if the early resolution they seek to achieve is thwarted by a mistaken belief that pre-suit monetary exchanges must be reported to the Data Bank as though they were in settlement of an actual written demand for payment. The physicians whose participation is essential will be largely chilled. Even more importantly, nonmonetary goals such as explanation, reconciliation and safety improvement that can be addressed through early, nonlitigious communication¹⁵⁸ will likewise be largely thwarted.

D. Caveats: Dismissal, Abatement, and Voluntary Nonsuit

If the foregoing arguments are correct, namely that medical malpractice insurers should not report settlement payments made during the pre-suit notification period, several situations require special attention. When a plaintiff files suit without providing the required pre-suit notice, the court has a choice. It can dismiss the suit, with or without prejudice, or it can abate the claim and require that parties simply wait out the pre-suit period before proceeding with litigation. The plaintiff has an additional choice: Take a voluntary non-suit, which may or may not be followed by a proper pre-suit notice and a subsequent filed claim. Plaintiffs also can voluntarily non-suit even a properly noticed suit.

Courts differ considerably in addressing violations of pre-suit notice requirements. Texas, for instance, grants abatement on the ground that outright dismissal is too harsh a consequence:

[A]llowing tolling when a plaintiff sends notice without the authorization form gives the health care provider fair warning of an imminent claim and then allows the provider to obtain an abatement for negotiations and evaluation of the claim. We will not read an overly strict and unfounded requirement into section 74.051 when the plain language of the statute provides us with an unambiguous and reasonable meaning.¹⁵⁹

If a court thus opts for abatement and permits a prematurely filed malpractice claim to continue to exist, simply postponing its effectiveness, then plain language suggests there *is* a “written claim or demand for payment” on the table, and that any settlement reached during the time of

¹⁵⁸ See *supra* Part I.

¹⁵⁹ *Hill*, 247 S.W.3d at 360. See also *Schepps*, 652 S.W.2d at 938.

abatement must be reported to the Data Bank. That is, because the plaintiff has filed a bona fide malpractice suit and the court is merely delaying litigation activity for the required sixty days, any settlement would arguably count as payment in response to that demand.

In contrast, many other states dismiss an inappropriately filed claim. The Florida Court of Appeal expressly rejected abatement, holding that “we cannot simply abate what is, for all intents and purposes, a nonexistent lawsuit.”¹⁶⁰ Similarly, the Mississippi Supreme Court found that a suit filed without proper pre-suit notification is “not lawfully filed, and it is of no legal effect.”¹⁶¹ In these cases the courts make clear that no filed claim exists.

More recently a Tennessee Court of Appeal followed suit.¹⁶² The plaintiff had filed suit in 2005, prior to the enactment of that state’s pre-suit notification statute. She voluntarily nonsuited in February 2009, then re-filed her claim just under a year later, within the state’s one-year savings statute.¹⁶³ However, because the plaintiff failed to comply with the pre-suit notice state’s and certificate of merit requirements in re-filing, her complaint was dismissed on the ground that it was a “new action” subject to those requirements.¹⁶⁴ Other courts provide similar analyses.¹⁶⁵

In these cases plain language would suggest that, where a court has declared that no claim exists, if parties settle before any genuine malpractice claim is on the table, the monetary payment will not be reportable. After all,

¹⁶⁰ *Pearlstein*, 500 So. 2d at 587.

¹⁶¹ *Thomas*, 999 So. 2d at 846.

¹⁶² *Cude v. Herren*, No. W2010-01425-COA-R3-CV (Tenn. App. September 26, 2011).

¹⁶³ *Id.* at *2.

¹⁶⁴ *Id.* at *5.

¹⁶⁵ *See, e.g., Pitalo v. GPCH-GP, Inc.*, 933 So. 2d 927, 929 (Miss. 2006) (noting plaintiff’s failure to send notice at any time “is an inexcusable deviation from the Legislature’s requirements for process and notice under MISS. CODE ANN. § 15-1-36(15), and such failure warrants dismissal of her claim.”); *South Miami Hosp. v. Perez*, 38 So. 3d 809 (Fla. Dist. Ct. App. 2010) (“Because the respondent’s claim is essentially a medical negligence action, she was required to comply with the pre-suit notice and other requirements of chapter 766, Florida Statutes. Having failed to do so, the amended complaint should have been dismissed.”); *Oakwood Hosp. Corp.*, 575 N.W.2d at 75 (“This Court must follow the rule of law established by a prior published decision of this Court. MCR 7.215(H). Thus, in light of *Morrison*, we conclude that we are required to hold that dismissal without prejudice was the appropriate remedy for plaintiff’s noncompliance with § 2912b(1) in this case.”). *See also Bush v. Shabahang*, 772 N.W.2d 272 (Mich. 2009) (dismissing case, but without prejudice); *Hosp. Corp. of Am. v. Lindberg*, 571 So. 2d 446, 449 (Fla. 1990) (dismissal with leave to amend).

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although an “entity” is paying, it is not paying to settle a “medical malpractice action or claim.”¹⁶⁶ There is no claim before the court once it is dismissed and declared to have been a nonentity all along. Also of note, decisions such as this one lend further credence to the argument, in Part IIIC, that during the pre-suit notification period, no “written claim or demand” exists that could be deemed to trigger any mandate that an insurer to report to the NPDB.

Arguably a similar response applies to a plaintiff’s voluntary nonsuit, and to a dismissal with leave to amend and re-file. The Supreme Court of Florida, for instance, permits re-filing:

We therefore hold that, in medical malpractice actions, if a pre-suit notice is served at the same time as a complaint is filed, the complaint is subject to dismissal with leave to amend. The plaintiff may subsequently file an amended complaint asserting compliance with the pre-suit notice and screening requirements of section 768.57 and the pre-suit investigation and certification requirements of section 768.495(1). We note, however, that counsel for the defendants will be entitled to fees and costs resulting from the premature filing of the lawsuit, and such fees could be assessed against the plaintiff. Further, willful noncompliance with the pre-suit screening process can still result in dismissal of claims or defenses, as provided in section 768.57(3)(a).¹⁶⁷

Here, as just above, so long as the suit does not currently exist, then even if it might reappear at some point in the future, any payment made during the interim period is arguably not a payment made to settle a written claim or demand. During that period there simply is no written claim or demand.

¹⁶⁶ 42 U.S.C. § 11131(a) (2006).

¹⁶⁷ *Hosp. Corp. of Am.*, 571 So. 2d at 449. See also *Davis v. Mound View Health Care, Inc.*, 640 S.E.2d 91, 95–96 (W. Va. 2006) (“[t]he Rules do not specifically provide such a presumption where an action is involuntarily dismissed upon a defendant’s motion for a plaintiff’s failure to comply with statutory pre-filing notice requirements. The specification as to whether a dismissal is with or without prejudice is significant. Where a dismissal is without prejudice, our savings statute, W. VA. CODE § 55-2-18 may be utilized to permit the re-filing of a medical malpractice action involuntarily dismissed for failure to comply with the mandates of W. VA. CODE § 55-7B-6 because such dismissal would not be a dismissal on the merits.”) (emphasis omitted).

IV. MORAL HAZARD

If the foregoing analysis is correct, then medical malpractice insurers and other such entities should refrain from reporting payments under a variety of circumstances:

- when a practitioner pays out of pocket;
- when the practitioner forgives or repays the patient's debt;
- when a claim or demand for payment is made orally rather than in writing;
- when the physician voluntarily (though not in writing) discloses that s/he erred and offers the patient compensation;
- when a hospital or other organization pays and an individual practitioner's name is dropped from the suit (corporate shield);
- when parties have agreed, or statutes require, that mediation take place before any written complaint may be filed, and the settlement occurs during such mediation; and
- during the pre-suit notification period many states require, including when a court has determined that a prematurely filed complaint has been dismissed and not merely abated.

These conclusions may leave some readers unsettled. Isn't the purpose of the NPDB to keep tabs on incompetent practitioners and, in the process, protect the public from harm? Is it really a "victory" to protect such providers from having their mistakes duly recorded and potentially used as a basis for limiting the damage they can do to the next patient? Indeed, as DHHS has pondered aloud, doesn't the "corporate shield" (and by implication, other ways of avoiding NPDB reports) potentially "mask the extent of substandard care and diminish NPDB's usefulness as a flagging system?"¹⁶⁸

No. For a variety of reasons, these "moral hazard" concerns should not keep us from trying to resolve adverse events early, and to recognize that in many instances such settlement payments need not and should not be reported to the Data Bank. Briefly, these reasons are that (a) Data Bank reporting deters rather than enhances quality improvement; (b) the quality and reliability of NPDB malpractice data are seriously deficient and, indeed, the mandate to report is essentially unenforceable; (c) HCQIA's assumption that hospital credentialing processes are the optimal locale for monitoring

¹⁶⁸ "The NPDB serves primarily as an alert or flagging system intended to facilitate a comprehensive review of health care practitioners' professional credentials." NPDB 2007-2009 Annual Report, *supra* note 115, at 8. NPDB 2005 Annual Report, *supra* note 115, at 30; NPDB 2006 Annual Report, *supra* note 115, at 34.

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physicians has now become archaic; and (d) emerging alternative avenues for monitoring physician quality are greatly superior to the HCQIA's outdated approach. As a reminder, these arguments are aimed exclusively at the Data Bank's medical malpractice reports¹⁶⁹—not at its reports of sanctions undertaken by states' medical boards¹⁷⁰ or its reports by hospitals and related entities regarding adverse professional review actions.¹⁷¹

A. *Quality Improvement*

First and foremost, if the discussion in Part I is correct, litigation is powerfully antithetical to improving the quality and safety of patient care, in large part because it discourages communication that is essential to identifying and exploring the underlying problems that need to be fixed. To the extent that the Data Bank encourages physicians to continue litigating rather than to seek an early and multi-faceted resolution,¹⁷² it directly threatens important avenues of communication and quality improvement that are well-recognized today, but little-known back in 1986 when HCQIA was enacted.

Such a result would contravene the very purpose of the law that created the NPDB. The Health Care Quality Improvement Act was enacted amidst express Congressional findings, such as: “The increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any individual State.”¹⁷³

Congress chose hospital peer review, fueled by Data Bank information, as its preferred mechanism for improving quality by “restrict[ing] the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance.”¹⁷⁴ Thus, Congress' overriding emphasis in the Act was to improve the quality of health care. If hospital peer review was the most effective vehicle at that time—and quite possibly it was—this is no longer

¹⁶⁹ 42 U.S.C. § 11131 (2006).

¹⁷⁰ 42 U.S.C. § 11132 (2006).

¹⁷¹ 42 U.S.C. § 11133 (2006).

¹⁷² As noted above, physicians became less willing to settle cases shortly after the NPDB became fully operational, expressly because of Data Bank concerns. *See Waters et al.*, *supra* note 64, at 290; *Smarr*, *supra* note 64; *see also Mello & Gallagher*, *supra* note 64.

¹⁷³ 42 U.S.C. § 11101(1) (2006).

¹⁷⁴ *Id.* at § 11101(2).

true today, as discussed below. For now we may observe that avoiding Data Bank reports wherever legally permissible appears, in fact, to be more rather than less consistent with this ultimate Congressional intent.

Indeed, further evidence of this evolution emerges in the Patient Protection and Affordable Care Act of 2010.¹⁷⁵ The Act authorized the Secretary of DHHS to award grants “for the development, implementation, and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations.”¹⁷⁶ Applicants for these grants were asked to show how their proposal, *inter alia*:

- (A) makes the medical liability system more reliable by *increasing the availability of prompt and fair resolution* of disputes;
- (B) encourages the efficient resolution of disputes;
- (C) encourages the *disclosure* of health care errors;
- (D) *enhances patient safety by detecting, analyzing, and helping to reduce medical errors and adverse events.*¹⁷⁷

To the extent that the NPDB chills physicians’ willingness to participate in such alternatives, it appears to be in direct conflict with Congress’ current intent.

B. Degradation of NPDB Data and its Utility: Garbage In, Garbage Out

For a wide variety of reasons, information in the malpractice portion of the Data Bank should not be deemed a reliable indication of whether or how often a practitioner has committed malpractice—i.e., whether he is an “incompetent physician” as contemplated by the statute.¹⁷⁸ DHHS expressly recognizes that a Data Bank report does not necessarily betoken malpractice.¹⁷⁹ Unfortunately, the limits of Data Bank integrity and

¹⁷⁵ Patient Protection and Affordable Care Act of 2010, Pub. L. 111–148, 124 Stat. 119 (to be codified as amended at scattered sections of the Internal Revenue Code and in 42 U.S.C.).

¹⁷⁶ 42 U.S.C. § 280g-15 (2006).

¹⁷⁷ 42 U.S.C. § 280g-15(c)(2) (2006) (emphasis added).

¹⁷⁸ *Id.*

¹⁷⁹

The NPDB acts primarily as a flagging system; its principal purpose is to facilitate a comprehensive review of professional credentials. Information on medical

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completeness are considerably worse than DHHS may recognize. Arguably its medical malpractice entries are no longer useful even as a flagging system.

1. Medical Malpractice Reports Do Not Capture Malpractice Well

As discussed in Part I, studies reveal that there is very little connection between negligent iatrogenesis and a filed medical malpractice claim: Most negligence does not result in a claim, and most claims are not linked with negligence.¹⁸⁰ In other cases physicians may deem it appropriate to compensate patients for adverse outcomes that are clearly not negligent.

For example, it is not uncommon for anesthesiologists or certified registered nurse anesthetists to dislodge a tooth or filling during intubation or extubation. This is often caused by the poor condition of the patient's dentition, and can result in a small settlement to compensate the patient for damage or replacement, which must be reported to the NPDB.¹⁸¹

2. Medical Malpractice Reports Appear Significantly Late

Whereas an early settlement would appear virtually immediately in the Data Bank, a litigated medical malpractice resolution takes far longer.

malpractice payments, certain adverse licensure actions, adverse clinical privilege actions, adverse professional society membership actions and Medicare/Medicaid exclusions is collected from and disseminated to eligible entities.

NPDB GUIDEBOOK, *supra* note 77, at E-1.

"The Secretary of HHS understands that some medical malpractice claims (particularly those referred to as nuisance claims) may be settled for convenience, not as a reflection on the professional competence or professional conduct of a practitioner." *Id.* at E-9.

"A payment in settlement of a medical malpractice action or claim shall not be construed as creating a presumption that medical malpractice has occurred." 45 C.F.R. § 60.7(d) (2010).

¹⁸⁰ See *supra* note 3 and accompanying text. See also Brennan, *supra* note 3; Dauer & Marcus, *supra* note 1, at 190; Lucian L. Leape, *Error in Medicine*, 272 JAMA 1851, 1851 (1994); A. Russell Localio et al., *Relation Between Malpractice Claims and Adverse Events Due to Negligence, Results of the Harvard Medical Practice Study III*, 325 NEW ENGL. J. MED. 245, 245–51 (1991); Yee, *supra* note 3, at 423–24 (physicians make more errors during immediate period after being sued).

¹⁸¹ Smarr, *supra* note 64, at 69.

According to the DHHS annual NPDB reports, the average duration from the time an incident occurs to the time a payment is made is over four and a half years, and in some states nearly eight years.¹⁸² By the time a payment appears in the Data Bank it is seriously out of date. Even if a report were indicative of malpractice at the time of the incident, it does not follow that the physician is still “incompetent” years later. Its value as an alert to peer reviewers is thus considerably attenuated.

A second problem is that, as noted, the physician is encouraged to litigate. The longer he hangs on, the longer it takes to reach a resolution and thereafter to see a Data Bank report. And because physicians prevail so much of the time when they litigate instead of mediate, the odds are limited that any report will be made at all—even where the physician’s care truly was negligent.

3. *Underreporting, Unenforceability*

In theory, entities such as medical malpractice insurers have a significant incentive to report to the Data Bank each time they pay a settlement or judgment on behalf of a practitioner. After all, failure means a potential penalty of \$11,000 per instance. In reality, however, significant underreporting is almost certainly occurring. In 2000 the U.S. General Accounting Office (GAO) found high levels of errors among all reports (malpractice, peer review, and licensure actions).¹⁸³ Specifically regarding medical malpractice reports the GAO observed that, although the Health Services Resource Administration (HRSA):

has been concerned that malpractice payments are underreported, it has not been able to determine the magnitude of the problem despite many years of effort. Medical malpractice payments can be underreported in two ways,

¹⁸² Per the NPDB 2005 Annual Report the average duration was 4.66 years, up eighteen days from 2004. The delay varied among states, from 3.20 years in Oregon to 6.16 years in Massachusetts. NPDB 2005 Annual Report, *supra* note 115, at 8. Per the next year’s report: “[D]uring 2006 payments were made most quickly in South Dakota (a mean payment delay of 3.26 years) and California (3.30 years). Payments were slowest in Alaska (7.83 years) and Massachusetts (6.60 years).” NPDB 2006 Annual Report, *supra* note 115, at 33. The most recent NPDB Annual Report does not update these figures. See NPDB 2007-2009 Annual Report, *supra* note 115. See also Smarr, *supra* note 64, at 71–72 (noting nearly five-year lag means NPDB fails to provide timely information).

¹⁸³ U.S. GEN. ACCOUNTING OFFICE, NAT’L PRACTITIONER DATA BANK: MAJOR IMPROVEMENTS ARE NEEDED TO ENHANCE DATA BANK’S RELIABILITY GAO-01-130, at 5, 10–13 (2000), available at <http://www.gao.gov/new.items/d01130.pdf>.

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neither of which has been successfully quantified. First, agency officials believe that some insurers may be using a technicality in NPDB's reporting requirements to avoid reporting some practitioners. Second, agency officials believe that some insurers and self-insured organizations such as HMOs and other health plans should report to NPDB but do not.¹⁸⁴

The report then makes a crucial point: "HRSA has not yet identified or fined any organizations for failing to report the required information. Agency officials told us that they are reluctant to impose fines because they believe that the cost of levying and collecting civil penalties often exceeds the \$11,000 maximum amount that can be assessed."¹⁸⁵

A major part of the problem is that there is apparently no reliable way for HRSA to track whether and when insurers actually make malpractice payments in the first place, to be able to match those with Data Bank reports. In one effort to track down discrepancies between payments and reports, HRSA used malpractice claims data that insurance companies voluntarily reported to an umbrella organization, the National Association of Insurance Commissioners (NAIC).¹⁸⁶ However, any Data Bank report verification done via comparisons with the NAIC data base is of limited value, since reports to that organization are completely voluntary. Insurers who wish to avoid being caught for failure to make NPDB reports need only to refrain from making voluntary reports to the NAIC, and there will be no discrepancy for HRSA to observe.

Of interest, the most recent NPDB Annual Report does little to address this issue. Although it states that compliance activities were enhanced for 2007, 2008, and 2009, these activities were directed toward such entities as "the DEA, Medicaid Fraud Control Units (MFCU), the National Council of

¹⁸⁴ *Id.* at 10.

¹⁸⁵ *Id.*

¹⁸⁶ *Id.* at 12.

[HRSA] identified 41 insurers that reported payments to NAIC but not to NPDB. HRSA contacted these companies seeking explanations regarding the differences in the reported payments. As of September 2000, 17 of the 41 companies have adequately explained the discrepancies to HRSA. For instance, NAIC data, for some companies, reflect total payments made by their corporations—combining payments made on behalf of individual practitioners with payments made on behalf of organizations. NPDB data only represent payments made on behalf of individual practitioners. Of the remaining 24 companies, 18 recognized their omissions and agreed to file the delinquent reports. The other six companies have not responded to HRSA's inquiries and have been warned by the agency that they will be reported to HHS/OIG for possible enforcement action.

State Boards of Nursing, the Federation of Chiropractic Licensing Boards, and the National Association of Boards of Pharmacy.”¹⁸⁷ The Report asserts that compliance was monitored and that the Division of Practitioner Data Bank “ensured that medical malpractice and adverse actions were being reported to the NPDB.”¹⁸⁸ However, there is no indication just how such reports were being ensured. The closest information on point indicates only that, regarding hospitals’ mandate to report adverse actions regarding practitioners’ privileges, many hospitals have never reported anything whatever to the NPDB.¹⁸⁹ Hence, it is not clear just what sort of ramped-up enforcement is being described in this latest NPDB Annual Report.

In sum, it appears that there is little way for HRSA to figure out whether insurers are actually reporting as required. Because the cost of enforcement exceeds the value of the penalty assessed against the insurer, HRSA has little incentive to enforce the mandate even where it detects violations.

The NPDB’s mandate to report malpractice payments thus appears unenforceable.

This essentially inevitable underreporting presents obvious problems. First, if the goal of the Data Bank is to alert hospital peer review entities to physicians who may be poor practitioners, this obviously can not happen where a report is never made. Second, significant underreporting will inappropriately stigmatize those physicians who actually land in the Data Bank, if in fact a significant number of other physicians with comparable medical malpractice records are never reported.

It might be replied that HCQIA requires that any malpractice report made to the Data Bank must also be forwarded to state licensing boards,¹⁹⁰ and that many states require malpractice payments to be directly reported to state licensure boards.¹⁹¹ Although true, the actual consequences of these

¹⁸⁷ See NPDB 2007-2009 Annual Report, *supra* note 115, at 19, 24, 29, 35.

¹⁸⁸ *Id.* at 20.

¹⁸⁹ *Id.* at 72–73.

¹⁹⁰ 42 U.S.C. § 11134(c)(1), (2) (2006).

¹⁹¹ See, e.g., FLA. STAT. § 456.049 (2007) (requiring practitioners to report claims or actions for damages to the Office of Insurance Refutation); FLA. STAT. § 456.041(4) (2007) (requiring reports of payments exceeding \$100,000 to the Department of Health); KY. REV. STAT. ANN. § 304.40-310(1), (2) (WEST 2008) (requiring reports of malpractice claims settled or finally adjudicated to be made to the commissioner of insurance, who must forward the information to the appropriate licensing board); OHIO REV. CODE ANN. § 4731.224(D) (WEST 2008) (requiring that any professional liability insurer notify the state medical board of any settlement or payment exceeding \$25,000); KAN. STAT. ANN. § 65-2836(x) (2008) (permitting license revocation for any physician or other licensee who has “failed to report to the board any adverse judgment, settlement or award against

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reports appear to be considerably less significant than reports in the Data Bank. Some state-mandated reports are purely for informational purposes.¹⁹² Also, state medical boards do not often impose sanctions simply because a physician has paid for purported malpractice. Rather, license restrictions on the whole are relatively rare and are more likely to follow offenses such as unprofessional conduct, sexual misconduct, misprescribing of controlled substances, or similarly salient problems.¹⁹³ In 2002, negligence accounted for less than 15% of state boards' disciplinary actions. The most common resolution, in two-thirds of cases, was a private agreement in which the physician was not found guilty of the alleged offense.¹⁹⁴ More importantly, if state boards' reporting requirements were to deter physicians from early resolution in the same way as the NPDB, they should arguably be reshaped.¹⁹⁵

the licensee resulting from a medical malpractice liability claim . . ."); COLO. REV. STAT. § 10-1-120 (2010) (requiring each medical malpractice insurer to send information to the state medical board regarding each medical malpractice claim for which a settlement or judgment has been paid); ARK. CODE ANN. § 17-95-103 (1975) (physicians must notify the medical board of each medical malpractice claim).

¹⁹² FLA. STAT. § 456.041(4) (2007) (requiring reports to the Department of Health of payments exceeding \$100,000).

¹⁹³ See, e.g., Lena H. Sun, *State Boards Don't Always Discipline Doctors Sanctioned by Hospitals*, WASH. POST, March 16, 2011, 12:27 a.m., <http://www.washingtonpost.com/wpdyn/content/article/2011/03/16/AR2011031605966.html>; Alan Levine et al., *State Medical Boards Fail to Discipline Doctors with Hospital Actions Against Them*, PUBLIC CITIZEN, March 15, 2011, available at <http://www.citizen.org/documents/1937.pdf> (noting that nearly half of physicians disciplined by hospitals had escaped any licensure action, and that the most common categories of failure to take licensure action included physicians who posed an immediate threat to health or safety, were incompetent or negligent, provided substandard care, or who engaged in sexual misconduct, fraud or narcotics violations).

¹⁹⁴ Darren Grant & Kelly C. Alfred, *Sanctions and Recidivism: An Evaluation of Physician Discipline by State Medical Boards*, 32 J. HEALTH POL. POL'Y & L. 867, 874 (2007). See also Sidney M. Wolfe et al., *Public Citizen's Health Research Group Ranking of State Medical Boards' Serious Disciplinary Actions: 2007–2009*, PUBLIC CITIZEN, April 5, 2010, available at <http://www.citizen.org/documents/1905.pdf>; Sidney M. Wolfe & Kate Resnevic, *Public Citizen's Health Research Group Ranking of State Medical Boards' Serious Disciplinary Actions: 2006–2008*, PUBLIC CITIZEN, April 20, 2009, available at <http://www.citizen.org/documents/HRG1868.pdf>.

¹⁹⁵ Some states also place malpractice information in public view:

According to a recent review, thirty-two states post physician profiles on the Internet for use by consumers. While most sites contain discipline and license data, many states also include physician-specific information on medical malpractice judgments, with a handful disclosing malpractice settlements as well. Rhode Island

4. *Imbalanced Reporting: Consent-to-Settle Clauses*

A key assumption behind the NPDB is that a payment made to settle a malpractice claim implies that the physician must have erred in some way, at least in most cases. This assumption arises partly from the fact that many physicians' malpractice insurance contracts feature a "consent to settle" clause, that is, a clause permitting the physician to veto any effort to settle the case without her permission. If the physician believes he has not erred, he can defend himself as long as the courts permit, and in most cases will win the case.

This assumption is inapplicable, however, for physicians whose policies lack such a clause.¹⁹⁶ In these cases a settlement can reflect, not any evaluation that the physician erred, but simply a business judgment that it is less costly to settle than fight. Indeed, the state of Florida directly forbids such clauses. Per Fla. Stat. Ann. § 627.4147(b)(1):

It is against public policy for any insurance or self-insurance policy to contain a clause giving the insured the exclusive right to veto any offer for admission of liability and for arbitration made pursuant to s. 766.106, settlement offer, or offer of judgment, when such offer is within the policy limits. However, any offer of admission of liability, settlement offer, or offer of judgment made by an insurer or self-insurer shall be made in good faith and in the best interests of the insured.¹⁹⁷

Of note, Florida courts have been reluctant to consider that the physician's professional reputation or the potentially adverse implications of a Data Bank report will count as that physician's "best interests" under this statute. Per a Florida appellate court, "[t]he 'best interests of the insured,' within meaning of statute . . . means the interests of the insured's rights under the malpractice policy, not some collateral effect unconnected with the

and Florida have online report card systems that exclude liability suit information. Massachusetts and New York have systems that include a summary of doctors' liability histories, including selected information on malpractice settlements. California recently approved the creation of a system that would disclose settlement information for repeat offenders.

Sage et al., *supra* note 3, at 1288 (citations omitted).

¹⁹⁶ *Id.* See also Smarr, *supra* note 64, at 60–70.

¹⁹⁷ *But see* CAL. HEALTH & SAFETY CODE § 1306 (forbidding insurers from entering into settlement exceeding \$3000 without the written consent of the insured).

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claim.”¹⁹⁸ Similarly, in *Freeman v. Cohen*¹⁹⁹ the appellate court agreed with the insurer that “[t]he policy’s purpose was indemnification and a defense of covered claims, not to protect the insured from increases in insurance premiums or damage to his reputation from a paid claim.”²⁰⁰

Nationwide, a number of medical malpractice policies lack a consent-to-settle clause, thereby permitting purely business-based settlement decisions.²⁰¹ As it is not clear what proportions of physicians have versus lack such a clause, likewise we do not know what portion of malpractice reports in the Data Bank are the product of business expediency decisions in response to unfiltered allegations, and what portion reflect genuine malpractice. The government’s simple caveat that “[a] payment in settlement of a medical malpractice action or claim shall not be construed as creating a presumption that medical malpractice has occurred”²⁰² is not particularly helpful.

5. Imbalanced Reporting: Government Physicians

The problem of wide variation in the quality of Data Bank information is exacerbated when we add government-employed physicians. When someone is allegedly injured by the acts of a federal employee, the Federal Tort Claims Act²⁰³ is implicated rather than state law, and the plaintiff generally sues the federal government rather than the particular government employees involved. Accordingly, HCQIA required the Secretary of DHHS to explore how the statute would apply to government-employed health care

¹⁹⁸ *Rogers v. Chicago Ins. Co.*, 964 So. 2d 280, 284 (Fla. Dist. Ct. App. 2007). In *Rogers*, the insurer had ninety days to investigate the claim, but did not begin to do so until the deadline was nearly expired. The insurer opted to settle the case instead of fight. The Florida Court of Appeal upheld the insurer’s right to settle, denying the physician’s claim that settling exhibited bad faith. See also Robert Rubin, *Legal, Practical, and Ethical Considerations of Medical Malpractice Settlements*, 83 FLA. BAR J. 47 (2009).

¹⁹⁹ *Freeman v. Cohen*, 969 So. 2d 1150 (Fla. Dist. Ct. App. 2007).

²⁰⁰ *Id.* at 1155. See also Thomas E. Dukes & Helen V. Owens, *Settlements and Releases in Malpractice Claims*, in FLORIDA MEDICAL MALPRACTICE HANDBOOK MALP FL-CLE 16-1 (2006).

²⁰¹ See, e.g., *Teague v. St. Paul Fire and Marine*, 974 So. 2d 1266, 1269 (La. 2008); *Rohart v. Melsar Risk Mgmt. Servs.*, 2009 WL 5068585 (Fla. Dist. Ct. App. 2008); Brief for Appellant, *Shega v. Lewis*, 1999 WL 33895195 (Cal. Ct. App. 1999) (although insured physician had a consent-to-settle clause, the insurer settled without informing insured physician and thus without insured’s express consent).

²⁰² 45 C.F.R. § 60.7(d) (2010).

²⁰³ 28 U.S.C. §§ 1346(b), 2671–80 (2006).

practitioners, then enter into memoranda of understanding (MOU) with the Secretary of Defense, the Administrator of Veterans Affairs, and the Administrator of the Drug Enforcement Administration.²⁰⁴

The MOUs that emerged created a peer review process to function as an intermediary between a medical malpractice payment and a Data Bank report.²⁰⁵ They thereby created very different standards for reporting government physicians, than for ordinary physicians.²⁰⁶ Military physicians, for instance, can only be reported if several layers of senior evaluation, including the respective military branch's Surgeon General, determine that the physician actually committed malpractice, and further that this caused the plaintiff's injury. The military review system thus can decline to report to the NPDB, even when a court has found the physician at fault for malpractice.²⁰⁷

²⁰⁴ 42 U.S.C. § 11152(b)–(c) (2006); *see also* NPDB 2007-2009 Annual Report at 10.

²⁰⁵ U.S. GEN. ACCOUNTING OFFICE, NAT'L PRACTITIONER DATA BANK: MAJOR IMPROVEMENTS ARE NEEDED TO ENHANCE DATA BANK'S RELIABILITY GAO-01-130, at 12 (2000), *available at* <http://www.gao.gov/new.items/d01130.pdf>.

²⁰⁶ Per the NPDB 2006 Annual Report, *supra* note 115, at 17–18, 34:

The Secretary signed an MOU with the U.S. Department of Defense (DOD) September 21, 1987, with the DEA on November 4, 1988 (revised on June 19, 2003), and with the U.S. Department of Veterans Affairs (VA) November 19, 1990. In addition, MOUs with the U.S. Department of Transportation, U.S. Coast Guard and with the U.S. Department of Justice, Bureau of Prisons were signed June 6, 1994 and August 21, 1994, respectively. Policies under which the Public Health Service participates in the NPDB were implemented November 9, 1989 and October 15, 1990.

²⁰⁷ The process is elaborate:

The U.S. Department of Defense's (DOD) policy requires malpractice payments to be reported to the NPDB only if the practitioner was responsible for an act or omission that was the cause (or a major contributing cause) of the harm that gave rise to the payment. Also, it is reported only if at least one of the following circumstances exists about the act or omission: (1) The Surgeon General of the affected military department (Air Force, Army, or Navy) determines that the practitioner deviated from the standard of care; (2) The payment was the result of a judicial determination of negligence and the Surgeon General finds that the court's determination was clearly based on the act or omission; and (3) The payment was the result of an administrative or litigation settlement and the Surgeon General finds that based on the case's record as whole, the purpose of the NPDB requires that a report be made. The U.S. Department of Veterans Affairs (VA) uses a similar process when deciding whether to report malpractice payments.

NPDB 2006 Annual Report, *supra* note 115, at 34. *See also* Veterans Health Admin., Dep't of Veterans Affairs, VHA HANDBOOK 1100.17, 6, 11, NAT'L

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This standard is completely different from that to which ordinary physicians are held. For an ordinary physician, an insurer's simple business decision can be sufficient to leave a black mark in the NPDB, as will a court judgment that reflects, not scientific evidence, but only jury emotion.

Matters are only marginally different in the case of physicians employed by DHHS, as for instance those working for the National Institutes of Health or the Indian Health Service. In principle, "all settled or adjudicated HHS medical malpractice cases must be reported to the NPDB. This policy applies to all cases regardless of whether the standard of care has been met."²⁰⁸

However, DHHS can make an exception and decline to report "those cases in which the adverse event was caused by system error."²⁰⁹ This exception appears eminently sensible, if the Data Bank's goal is to identify incompetent practitioners. After all, if the individual's error was mainly the product of far broader, system-level error(s), then it seems unfair to tag the individual physician as though he or she were primarily responsible for the outcome.

The implication, however, is that this caveat could effectively exclude nearly all the Data Bank reports that would otherwise be required. As observed in Part I, two decades' systems-level research into adverse medical outcomes has made it clear that rarely is an adverse outcome simply the

PRACTITIONER DATA BANK (NPDB) REPORTS, December 28, 2009, *available at* http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2135:

(c) Reporting to the NPDB is based on the finding by a Review Panel that there was substandard care, professional incompetence, or professional misconduct during an episode of care. . . .

(d) For each involved practitioner, the Medical Center Director's notification must state that the request for a statement does not imply blame or fault, but, rather, is the practitioner's opportunity to submit information for consideration by the Review Panel

(i). Submission of NPDB Reports. (1) Payment will be considered to have been made for the benefit of a physician, dentist, or other licensed health care practitioner when the Director, Office of Medical-Legal Affairs, notifies, per subparagraph 8h(1), the Medical Center Director that the conclusion (of at least a majority) of the Review Panel is that payment was related to substandard care, professional incompetence, or professional misconduct on the part of the physician, dentist, or other licensed health care practitioner. In any case where professional incompetence or professional misconduct is involved, coordination with other relevant processes should occur (e.g., Professional Standards Board, Disciplinary Appeals Board, or administrative investigations). . . .

See also 38 C.F.R. § 46.3(b) (2010) ("malpractice payment reporting").

²⁰⁸ NPDB 2006 Annual Report, *supra* note 115, at 17–18.

²⁰⁹ *Id.* at 18.

product of a single practitioner's carelessness.²¹⁰ Thus, where an NIH physician can show that system-level flaws either caused or significantly contributed to the adverse outcome, he need not be reported. Under otherwise identical circumstances, non-government physicians would be reported, because no such exception applies to them.

Perhaps not surprisingly, DHHS rarely reports its physicians to the Data Bank. In the first fifteen years of NPDB operation, DHHS agencies reported only 257 medical malpractice cases.²¹¹ By 2006, after a concerted effort to increase reporting, the sixteen-year total rose to 574, 30% of which were reported in 2006.²¹²

6. Imbalanced Reporting: Sovereign Immunity and Charitable Immunity

Somewhat analogously, many states permit physicians who provide charity care or who work for the state to be shielded from malpractice liability via charitable or sovereign immunity, respectively.²¹³ The state of Arkansas, for instance, provides that physicians who are retired but still licensed, and who render uncompensated or low-cost medical services at designated clinics "shall not be liable for any civil damages for any act or omission resulting from the rendering of such medical services, unless the act or omission was the result of such licensee's gross negligence or willful misconduct."²¹⁴

²¹⁰ See Part I's discussion of the Root Cause Analysis undertaken after the death of a sixteen-year-old obstetric patient caused by a medication error. What ostensibly appeared to be simple carelessness on the part of the nurse turned out, on closer analysis, to be the product of multiple layers of system-level problems. See Smetzer et al., *supra* note 19. See also Dekker, *supra* note 21; Leape, *supra* note 21; Denham, *supra* note 21.

²¹¹ NPDB 2005 Annual Report, *supra* note 115, at 15.

²¹² NPDB 2006 Annual Report, *supra* note 115, at 18. These numbers were not updated in the most recent report. See NPDB 2007-2009 Annual Report.

²¹³ See, e.g., UTAH CODE ANN. § 58-13-3 (2007); OKLA. STAT. ANN. tit. 51 § 152, 152-1, 152.2 (2006); LA. REV. STAT. ANN. § 40:1299.39 (2011); GA. CODE ANN. § 51-1-29.1(a)(1) (2011); TEX. CIV. PRAC. & REM. CODE ANN. § 74.003. See generally Carol A. Crocca, Annotation, *Validity, Construction, and Application of State Statutory Provisions Limiting Amount of Recovery in Medical Malpractice Claims*, 26 A.L.R. 5th 245 (1995).

²¹⁴ ARK. CODE ANN. § 17-95-106 (2010). See also ALASKA STAT. § 09.65.300 (2010); ARIZ. REV. STAT. § 12-571 (2003); DEL. CODE ANN. tit. 10, § 8135 (1999); D.C. CODE § 7-402 (2001); GA. CODE ANN. § 31-8-195.1 (2011); IDAHO CODE ANN. § 39-7703 (2011); 225 ILL. COMP. STAT. 60/31 (2006); IND. CODE § 34-30-13-1 (2010); MICH. COMP. LAWS, 333.16277 (2008); MISS. CODE ANN. § 11-1-71 (2008); NEB. REV. STAT. §

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Clearly, a physician who has charitable or sovereign immunity will not incur a Data Bank report under circumstances in which another physician, not similarly immunized, would be susceptible to a suit and a report.

7. Data Bank Reports can Cause Physicians Harm

As discussed in Part IIA, Data Bank reports can cause physicians real harm. One report can potentially cause a cascade of further consequences in which each successive institution sees the prior report(s), then circumscribes or revokes the physician's credentials, which in turn requires another Data Bank report that, in turn, can trigger additional adverse consequences for the physician's prerogatives to practice.²¹⁵ Such harms may be unintended where they befall physicians who are high-quality rather than the "incompetent" practitioners targeted by the act. But the effects are nonetheless real and, where they limit the practice of good physicians, they diminish rather than enhance quality of care—quite the reverse of Congress's intent.

8. Medical Malpractice Reports Largely Superfluous

Just as the Data Bank's medical malpractice reports are not particularly informative, evidence also suggests that they may also be superfluous. The federal government and a federal appellate court have both acknowledged that, even if a physician's malpractice payment is not listed in the Data Bank, that physician is likely to show up elsewhere in the Data Bank if he or she is a genuinely problematic practitioner. Thus, DHHS observes that "[p]hysicians with high numbers of Malpractice Payment Reports tended to have at least some Adverse Action Reports [licensure and/or clinical privilege reports] and Medicare/Medicaid Exclusion Reports, and vice versa."²¹⁶ Indeed, per a GAO report to Congress, "[i]ndustry experts ... point[] out that disciplinary actions taken by health care providers

25-21,188.02 (2010); N.C. GEN. STAT. ANN. § 90-21.16 (2009); N.D. CENT. CODE § 32-03.1-02.2 (2010); OHIO REV. CODE ANN. § 2305.234 (2004); OKL. ST. ANN. tit. 76, § 32 (2011); S.C. CODE ANN. § 44-7-50 (1976); TENN. CODE ANN. § 63-6-708 (2009); UTAH CODE ANN. § 58-13-3 (1953) (2007); WASH. REV. CODE ANN. § 4.24.300 (2005); W. VA. CODE § 30-3-10a (2011); WYO. STAT. § 1-1-129 (1977).

²¹⁵ See *Chudacoff*, 609 F. Supp.2d at 1166; *Doe v. Cmty. Med. Ctr.*, 221 P.3d at 661; *Cole*, 199 P.3d at 815.

²¹⁶ NPDB 2005 Annual Report, *supra* note 115, at 37–38. See also NPDB 2006 Annual Report, *supra* note 115, at 41.

and states are better indicators of professional competence than medical malpractice.”²¹⁷

Similarly, in *Am. Dental Ass’n v. Shalala*, the D.C. Circuit Court expressly acknowledged that, even where a malpractice payment does not appear in the Data Bank because the practitioner pays out of pocket, “those claims . . . will be reported if they come to the attention of an entity such as a peer review board.”²¹⁸ As the court then concluded, permitting self-paying practitioners to avoid a malpractice report to the Data Bank “does not fundamentally undermine the Act.”²¹⁹

C. Hospital Peer Review: Evolution into Anachronism

The HCQIA has itself become increasingly anachronistic. The anachronism emerges from several assumptions implicit in the statute. First, back in 1986, Congress, through HCQIA, seemed to presume that adverse outcomes were largely the product of individual persons and their carelessness and that if only we can reduce such poor practice, we can improve the safety and quality of health care.²²⁰ A corollary assumption was that if we can identify such poor practitioners and discipline them or restrict their practice, we will have significantly fewer adverse events. Third, HCQIA assumed that the best locus for identifying such errant individuals was the hospital and its peer review system.²²¹

From these assumptions the Act then inferred that if hospital peer review activities are protected by qualified immunity, and if these committees are provided with adequate information via the Data Bank, they will be able to reduce adverse events and thereby improve quality—first, by restricting or

²¹⁷ U.S. GEN. ACCOUNTING OFFICE, NAT’L PRACTITIONER DATA BANK: MAJOR IMPROVEMENTS ARE NEEDED TO ENHANCE DATA BANK’S RELIABILITY GAO-01-130, at 4 (2000), available at <http://www.gao.gov/new.items/d01130.pdf>.

²¹⁸ *Shalala*, 3 F.3d at 448.

²¹⁹ *Id.* Of note, once the *Shalala* court thus circumscribed the requirement to report malpractice payments in this way, Congress could have chosen to amend the statute to require that any payment by an “entity or person” must be reported. Congress chose not to do so, and that decision cannot be construed as accidental.

²²⁰ 42 U.S.C. § 11101(1) (2006).

²²¹ 42 U.S.C. § 11101(3) (2006). Although various peer review entities have the right to engage in peer review and check NPDB data (§ 11133), only hospitals are required to check the NPDB upon initial credentialing and every two years thereafter. Section 11135; 45 C.F.R. 60.13 (2010). Thus, hospital peer review was Congress’ main focus.

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removing poorly-performing physicians' opportunities to practice in the hospital setting and second, by reducing their opportunities to start anew in another location and perpetuate their errant practices.²²²

This picture has become anachronistic in several ways. To begin with, we now understand that adverse outcomes are largely the product of systems-level flaws, and are not usually reducible to incompetent individuals' slip-ups. Individuals do of course err. They become fatigued, distracted, harried, and hurried. But patient safety systems need to incorporate recognition of those human inevitabilities rather than simply punish them and admonish greater attentiveness.

A classic example concerns the anesthesiologist who, during surgery, reached into a drawer for the agent to reverse a sedated patient's chemical paralysis. Instead of grabbing the reversal agent, he grabbed the paralytic agent—clearly, an error. The broader problem was that both vials were side by side in the same drawer; both had yellow labels; both had yellow caps; both were the same size and shape. No harm came to the patient in this instance, but when the anesthesiologist related the incident to his colleagues he learned that almost universally they, too, had made the same error.²²³ Contemporary systems-analysis would recognize that amid a busy surgical setting such incidents are likely to happen. It makes far better sense to reorganize the drawer and to change the colors and shapes of labels and caps, than to punish anesthesiologists again and again for being human.

In addition to its outdated assumption that errant individuals should be the primary target for improving safety and quality, a second anachronism is HCQIA's reliance on hospital peer review as the key mechanism for catching such errant individuals. In 1986, nearly all physicians practiced in a hospital setting at least some of the time. Surgeons, anesthesiologists, and other invasive specialists had to use hospital-furnished operating rooms, catheterization labs, and the like. Primary care physicians who spent much of their day in an office also had to make hospital rounds on any patients who were hospitalized.

As a result, most physicians needed to have credentials and privileges at one or more hospitals. As a further result, Congress correctly discerned that at that time, hospitals had considerable leverage over physicians. Hospitals' medical staffs could more aggressively weed out poorly performing physicians if they could feel safe from antitrust and similar litigation, and if they had comprehensive information about which physicians were showing

²²² 42 U.S.C. § 11101(2) (2006).

²²³ Sheryl Gay Stolberg, *Do No Harm: Breaking Down Medicine's Culture of Silence*, N.Y. TIMES, Dec. 5, 1999, at D1.

poor performance, such as medical malpractice payouts, licensure restrictions, or adverse credentialing actions at some other hospital.²²⁴ Hence, Congress provided strong, albeit qualified, immunity for participating in peer review,²²⁵ created the NPDB to ensure a broad data base,²²⁶ and then required hospitals—but only hospitals—to check that Data Bank upon initial credentialing and every two years thereafter.²²⁷

Well into the twenty-first century, however, physicians' relationships with hospitals have changed dramatically. Many primary care physicians no longer find it efficient to round on their hospitalized patients, and instead delegate such duties to hospitalists.²²⁸ At the same time, many specialists have created free-standing ambulatory centers for surgery, invasive cardiology, interventionalist radiology, diagnostic and imaging evaluations of varying types, and numerous other services formerly provided only in a hospital. For these physicians, too, hospital credentials may not be important. The net result of this evolution is that many physicians' histories of adverse professional evaluations, as recorded in the Data Bank, are less and less likely to come to the attention of anyone likely to see and use that information.

²²⁴ 42 U.S.C. § 11101(3)-(5) (2006).

²²⁵ 42 U.S.C. § 11111-12 (2006).

²²⁶ 42 U.S.C. §§ 11131-11133 (2006).

²²⁷ 42 U.S.C. § 11135 (2006). Other entities such as state licensing boards and managed care organizations are permitted to view the data, but only hospitals are required to view it.

²²⁸ The term "hospitalist" was first coined in 1996—ten years after HCQIA was enacted. Hospitalists oversee the care of patients for the duration of an inpatient stay. Hospitalists become intimately familiar not just with serious illness, but also with the mechanics of how to get tests and procedures completed efficiently and with optimal planning for safe and efficient discharge. The goals include reduced length of stay and reduced morbidity and mortality. See Robert M. Wachter & Lee Goldman, *The Emerging Role of 'Hospitalists' in the American Health Care System*, 335 NEW ENGL. J. MED. 514, 514 (1996). See also Mary Beth Hamel, Jeffrey M. Drazen & Arnold M. Epstein, *The Growth of Hospitalists and the Changing Face of Primary Care*, 360 NEW ENGL. J. MED. 1141, 1141-42 (2009); Yong-Fang Kuo, Gulshan Sharma, Jean L. Freeman & James S. Goodwin, *Growth in the Care of Older Patients by Hospitalists in the United States*, 360 NEW ENGL. J. MED. 1102 (2009); *Frustrations With Hospitalist Care: Need to Improve Transitions and Communication*, 152 ANNALS INTERNAL MED. 469, 469 (2010); William N. Southern, Matthew A. Berger, Eran Y. Bellin, Susan M. Hailpern & Julia H. Arnsten, *Hospitalist Care and Length of Stay in Patients Requiring Complex Discharge Planning and Close Clinical Monitoring*, 167 ARCHIVES INTERNAL MED. 1869, 1869 (2007).

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D. Superior Approaches to Ensuring Practitioner Competence, Enhancing Safety

All of this is not to suggest that there is no such thing as an incompetent physician or that incompetent physicians cannot do harm. Neither is it to say that incompetent physicians should not be identified and either restricted or re-educated. It is to say, however, that we now need to identify far more effective ways of improving the safety and quality of care. We need not just to monitor practitioners' errors, but more broadly to assess their abilities to provide high quality care.

In the current economic climate, new structures are emerging that hope to do both, far better than a crude tally of the times an entity has paid money on behalf of a physician. As early as the 1990s, major corporations and business groups began to embrace "value-based purchasing" in the belief that the enormous sums they spent on health care should produce high-quality results. They began using their purchasing power to select superior providers, using various outcome measures.²²⁹

More recently, the Center for Medicare & Medicaid Services (CMS) has announced its own value-based purchasing initiative. It will incorporate clinical process-of-care measures in five health categories, such as heart failure and pneumonia, to influence its payments to providers.²³⁰ As CMS notes:

Medicare's current payment systems reward quantity, rather than quality of care, and provide neither incentive nor support to improve quality of care. Value-based purchasing (VBP), which links payment more directly to the quality of care provided, is a strategy that can help to transform the current payment system by rewarding providers for delivering high quality, efficient clinical care. Through a number of public reporting programs, demonstration projects, pilot programs, and voluntary efforts, CMS has launched VBP initiatives in hospitals, physician offices, nursing homes, home health services, and dialysis facilities.²³¹

²²⁹ Jack Meyer, Lise Rybowski & Rena Eichler, *Theory and Reality of Value-Based Purchasing: Lessons from the Pioneers*, AHRQ/AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, (1997), available at <http://www.ahrq.gov/qual/meyerrpt.htm>.

²³⁰ Cheryl Clark, *CMS Releases Value-Based Purchasing Incentive Plan*, HEALTHLEADERS MEDIA, (Jan. 11, 2011), available at <http://www.healthleadersmedia.com/content/HEP-261211/CMS-Releases-ValueBased-Purchasing-Incentive-Plan>.

²³¹ U.S. DEPT. OF HEALTH AND HUMAN SERVS., MEDICARE HOSPITAL VALUE-BASED PURCHASING PLAN DEVELOPMENT: ISSUES PAPER, (Jan. 17, 2007), available at

In a similar vein, Accountable Care Organizations (ACOs) appear likely to become a significant player in the health care landscape. They will feature partnerships or networks of hospitals, primary care providers, and others whose members will share savings achieved if they can reduce costs while maintaining or improving quality of care for their patient population—initially described as a Medicare population, but likely to be replicated by private health plans.²³² These ACOs, in turn, will emphasize that patients should have a “medical home” in which care is provided by a personal physician who can coordinate and integrate care with an eye toward serving the whole person. A medical home must use evidence-based medicine and continuous quality improvement, and will be financially rewarded for providing the added value of these sorts of services.²³³

In a variation on this theme, bundled payments for major units of service, such as a surgical procedure or even the care of patients with a chronic illness like diabetes, provide incentives for physicians, hospitals, and other providers to work together in ways that demand quality and accountability from all.²³⁴ Likewise, hospitals are increasingly purchasing physician practices, both primary care and specialists.²³⁵ Here, the hospital investigates the physician’s practice quality as part of its own due diligence and will

https://www.cms.gov/AcuteInpatientPPS/downloads/hospital_VBP_plan_issues_paper.pdf. See also Brian Betner, Adele Merenstein & Regan Tankersley, *Value-Based Purchasing Program—A Broad Overview*, HEALTH LAWYERS WEEKLY, VOL. 9, Jan. 28, 2011, available at <http://www.healthlawyers.org/News/Health%20Lawyers%20Weekly/Pages/2011/January%202011/January%2028%202011/CMSProposesRuleToImplementValue-BasedPurchasingProgramForIPPSHospitals.aspx>; VALUE BASED PURCHASING AND HEALTH CARE REFORM, available at <http://www.valuebasedpurchasing.com/>.

²³² Mark C. Shields, Jankaj H. Patel, Martin Manning & Lee Sacks, *A Model for Integrating Independent Physicians into Accountable Care Organizations*, 30 HEALTH AFF. 1, 1 (2011); Thomas L. Greaney, Anna D. Sinaiko & Meredith B. Rosenthal, *Accountable Care Organizations—The Fork in the Road*, 263 NEW ENGL. J. MED. e1 (2011); *Patients’ Role in Accountable Care Organizations*, 363 NEW ENGL. J. MED. 2583 (2011); Nat’l Comm. on Quality Assurance, *NCQA Patient-Centered Medical Home*, available at http://www.ncqa.org/Portals/0/Programs/Recognition/2011PCMHbrochure_web.pdf.

²³³ Carol Carden & Mark Dietrich, *A Valuation Model for the Formation of ACOs*, HEALTH LAWYERS WEEKLY, VOL. 9, Feb. 4, 2011, available at <http://www.healthlawyers.org/News/Health%20Lawyers%20Weekly/Pages/2011/February%202011/February%2004%202011/AValuationModelForTheFormationOfACOs.aspx>.

²³⁴ Struijs & Baan, *supra* note 119.

²³⁵ Robert Kocher & Nikhil R. Ashni, *Hospitals’ Race to Employ Physicians: The Logic Behind a Money-Losing Proposition*, 364 NEW ENGL. J. MED. 1790 (2011).

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customarily require far better quality data than clumsy Data Bank malpractice reports. They will continue their peer review processes and will, appropriately, report adverse credentialing actions to the Data Bank. Hospitals that own physician practices are more free, as are ACOs, to engage in early dispute resolution and to use the corporate shield to ensure that their physician employees are not penalized for participating actively in the process.

A major highlight of these economic developments is that value-seeking payment systems provide a substantial incentive to physician groups, ACOs, physician-hospital alliances and other entities to provide high-quality care. ACOs and kindred organizations must monitor their providers carefully. But they are not likely to accomplish this by consulting odd malpractice data from a Data Bank that provides at best a mish-mosh of largely uninterpretable events. Peer review will continue to be important, but it should no longer be predominantly seen as a traditional hospital committee keeping tabs on medical staff. Rather, these broader organizations must review physicians' day-to-day performance, including that of primary care physicians who may never admit patients to the hospital, and must likewise keep tabs on surgeons and proceduralists who may practice exclusively in ambulatory facilities.

V. CONCLUSION

This discussion suggests that HCQIA's requirement to report medical malpractice payments to the National Practitioner Data Bank has worked out rather poorly. Indeed, Sage et al. recommend that malpractice reporting provisions be deleted entirely²³⁶—a conclusion with which this author does not disagree.²³⁷ “[T]he malpractice reporting portion of the NPDB should be

²³⁶ Sage et al., *supra* note 3, at 1264, 1300, 1307 (“[o]verall, however, it is likely that patients would be better off if the malpractice reporting provisions of the NPDB were repealed, not least because NPDB information appears to be of limited utility for purposes of rating physician quality.”).

²³⁷ Indeed, in as Congress contemplated whether to include malpractice reports in the NPDB, it recognized the limited quality of such data.

With all of its faults, the malpractice system has been the primary approach that aggrieved patients have taken to deal with inadequate medical care. Accordingly, malpractice data can provide important clues for evaluating the credentials of health care practitioners. ... [T]he Committee is well aware that malpractice data provide only clues, not conclusions. Any number of considerations other than the merits of a claim can affect the size and frequency of malpractice payments. The sympathy generated by the severity of an injury, the attractiveness of a claimant, the skill of a

repealed. As currently constituted, NPDB reporting discourages settlements of claims, impairs openness, prompts defensive medicine, and tempts hospitals to help physicians evade reporting—all without providing useful aggregate data that furthers performance improvement.”²³⁸

The Data Bank’s problems are myriad. First, the malpractice reporting requirement may actively thwart HCQIA’s goal of promoting quality improvement. It encourages physicians to prolong litigation and thereby discourages the multi-faceted communication that is essential to understand and remedy the root causes of adverse outcomes. Indeed, a lack of communication is what prompts many patients to sue in the first place. Moreover, physicians’ NPDB-based reluctance to enter into early resolution can impair hospitals’ ability to create broad-based, problem-solving settlements—an approach that has been shown to arrive at fairer results for patients and families and to save considerable expense as well as redirect litigation defense funds toward quality improvement efforts.

Second, the Data Bank’s medical malpractice reports suffer from a host of distortions and inaccuracies that render them, at best, difficult to interpret and, at worst, effectively meaningless. Among those problems:

- Most filed claims are not related to negligent iatrogenesis, and most negligent iatrogenesis does not result in a filed claim;
- The reporting requirement is essentially unenforceable—first, because there is no way to ascertain whether or when a medical malpractice payment has been made, other than to compare it with a completely voluntary and therefore unreliable outside data base; and second, because HRSA acknowledges that enforcement is prohibitively costly when compared with the \$11,000 penalty that would be garnered from finding and fining a violator;
- Although some reports may reflect payments for malpractice settlements or judgments, others reflect exclusively a business decision to pay rather than fight, and there is no way to discern which are which;

claimant’s attorney, the demands of a busy medical practice and the unpredictability of juries can all lead health care practitioners to settle cases or lose verdicts with respect to medical services that meet or exceed accepted standards of medical care. Furthermore, even a legitimate malpractice claim does not automatically mean that a practitioner deserves disciplinary action. Any practitioner—even the most skilled and careful—can make an occasional mistake.

H.R. REP. NO. 99–903 (1986), *reprinted in* 1986 U.S.C.C.A.N. 6384 re. P.L. 99–660, 6396.

²³⁸ Sage, *supra* note 3, at 1307.

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- Although every medical malpractice payment must be reported for ordinary physicians, government-employed physicians are reported under completely different standards, and sovereign immunity and charitable immunity introduce further imbalance.

Third, the very purpose of collecting medical malpractice data—to inform hospital peer review committees in their credentialing and peer review decisions—has become largely anachronistic if deemed an effective way to spot and restrict incompetent physicians. Although peer review remains an important, indeed essential, element of quality and safety improvement, hospitals are no longer a key locus that can be counted on to monitor virtually every physician. In current health care, broader consortia of providers, such as integrated networks and ACOs, have significant and growing financial incentives to ensure that their practitioners are providing high-quality care. It is a re-direction of energy, away from emphasizing the errors of individual practitioners, toward learning from errors in order to improve care as a whole.

From these observations we conclude that the optimal course would simply be to remove medical malpractice payments from the National Practitioner Data Bank. They appear to do distinctly more harm than good. This would take an act of Congress, however, which may or may not happen in the near term. Shy of that, it is appropriate for practitioners and their insurers to take advantage of every lawful opportunity to avoid reporting to the Data Bank—that is, to welcome efforts by plaintiffs and attorneys to work with hospitals and other institutions who can invoke the corporate shield as part of a global resolution to a case, and to refrain from needlessly reporting payments made during a pre-suit notification period. Plaintiff attorneys should be encouraged to use oral communication whenever possible, and when they must file a pre-suit notice, to do so using the language of “potential” or “possible” claim, not simply of “claim.”

With conscientious use of HCQIA’s available flexibility, it is to be hoped that physicians can participate far more actively, and with considerably greater comfort than they do at present, in the kinds of early dispute resolution that can promote fairer settlements for patients and families, save on defense costs by avoiding needless litigation, and redirect efforts toward systematic quality improvement. Dodging the Data Bank can indeed be virtuous.

